Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 0**7**001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Day Physician/ Feb 14. Lillian Grove 3:20 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glynn Taff Asst. Living Catonsville Baltimore 8. Date of Birth
(Month, Day, Year)
1 1917 If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 X F Min. 577 30 9815 Hours Country) Minnesota Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 321 South Colington Ave 21231 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: 3 ♥ Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerical County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Ganzhorn Signe Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boyd Grove (Son) 321 South Collington Ave, Baltimore, MD 21231 permit. Page 1 and Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lee Crematory 2/18/2011 Clinton, Maryland 21. Signatur of Funeral Service Ligensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician several weeks Medical resulting in death) Due to (or a /a consequence of): Examiner a 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4 Pregnant 9 Unknown 5 Other (specify) Month Day Vear Pregnant at time of death 1 Yes 2 9 Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diseane Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been significate has been significated aftector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) In ambulance within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accider
Suicide 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, I Creek Layor UND 12754 15,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GETHA RASA MD, 4367 HOLLING FEM Ad, Baltonore, 2315 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** GOULDING 1419 1-ebnam 2011 even /Medical 4b. City, Town, or Locetion of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hagerstown
If Under 1 Year If Under 24 Hrs. 8. Date of Washington Medical Center Meritus 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, **Funeral** Hours 1 M 2□ F 189-44-3920 February Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Int If item 27 is marked other than "neturel; or items 23e or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at Hagerstown MD Washington 1XYes 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10a Street and Number 21740 Fairmont USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be moclure GOULDING REUP ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2: Department of Health ar Important: If item 27 Is eny injury or other trau 19912 Fairmont Ct. Hagerstown, MD 21740 Goulding Michael 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/23/11 Parklawns Mem. Gard. 4 □ Donation 5 Other (Specify) ENTOMB 22. Name and Address of Facility 297 Philadelphia, Ave 21. Signature of Funeral Service Licensee RESELLERS EHANC. Chambers burg : PA 17201 11101035 14. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ician and burial-trensit Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical the Due to (or as a consequence of) use as t jo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? funeral director, page 2 should 1 ☐ Yes 2 No 1 ☐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1_Inpatient 3□ DOA 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi ho completed cause of death (Item 23a) (Type, Print) 2911 5H-0 potenson 31. Date filed (Month

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieng Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 09 02 2011 9:25A^M John Joseph Geraghty /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20960 Colton Point Rd. St. Mary's Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year Hours 1 XM 2 □ F Days Min. Director 77 01/29/1934 Pennsylvania 173-26-5621 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Heatth and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra in activity to account the Medical Extra in activity of the Medical Extra in activities at the Medical Extra in 1 ☐ Yes 2 X No Director VA Fairfax Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7725 Tiverton Dr. 22152 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Private Law Practice Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Thomas Geraghty Agnes Theresa Ludwig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Geraghty 7725 Tiverton Dr. Springfield, Virginia 22152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 02/13/2011 Alexandria, VA 21. Signature of Funeral Service 22 Name and Address of Facility Advent Funeral Service 7211 Lee Hwy Falls Church, VA 22046 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death alure respirato Immediate Cause (Final **Physician** ardio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-tran requires that the death certificate be execu Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been s rector, page 2 should The law r 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shah M.D. 22650 Cedar Lane Ct. Leonardtown, MD 20650 Dr. Avani D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 9:30 PM 12 2011 February Ida Hicks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Edgewater South River Health & Rehab If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Aug 3 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Social Security Number **Funeral** 1 □ M 2√2 F 1931 Maryland 79 212-34-5885 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10h County 10a. State 1 ☐ Yes 2 No Maryland Anne Arundel Annapolis Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 2122 Willie Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Family Domestic 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hester Mackell Emory Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2122 Willie Dr. Annapolis, Md. 21401 Joseph Hicks(Husband) 20c. Location - City or Town, State 20a. Method of Disposition 20b НРастаф Dis Sodition (Notice of Ic cemetery, crematory or other place) 1

Burial 2 □ Cremation 3 □ Removal from State 2-21-11 Edgewater, Md. U.M. Church 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Winname Redese of Eacil Sons Mortuary, P.A. Zavoy S. Ases Moof 83 821 West St. Annapolis,
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a Was an has 2 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann Death filled in by the funeral 28b. Time of 28d. Describe how injury occurred after death. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

23

State Registrar

31. Date filed (Month, Day, Year)

September 18 2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

01077

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2011 State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Shirley Cherry Holloway February 14. 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Prince George's Cheverly 9. Birthplace (State or Foreign Country)
Wash.D.C. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🏻 F Hours 08/01/1929 81 Director 579-36-3954 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 X Yes 2 No P.G. Capitol Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 407 Rollins Avenue 20743 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 4 years Nurse/P.G.Co. Health Dept Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Curly Washington Corrine Hickman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Benjamin T. Holloway/Husband 407 Rollins Ave., Capitol Heights, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/22/11 Harmony Mem. Park Landover, Maryland Signature of Funeral Service License 22. Name and Address of Facility Renry S. Washington & Sons Co., Inc. any 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Unknown Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) requires that the death certificate be executed and that initiated events Due to (or as a consequence of): ng physician ar resulting in death) Last Physician/Medical P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year for Day Pregnant at time of death the 9 Unknown by s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

Of the Funeral Director: After this certificate has be your pleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 so autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Koolee aslino, uno 044885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6400 Marlboro Pike, District Heights, Maryland 20747 Roscoe Adams, M.D. 31. Date filed (Month, Day, Year)

Registrar

FEB 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}7, 2011 Physician/ February 8:05A Ernest Andrew Hitte, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday Funeral 1 😿 M 2 🗆 F (Month, Day, Year) Washington. 88 Director 577-60-6347 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Calvert Solomons 1 Tes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11750 Asbury Circle 20688 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Photographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mont. Important: If item 27 is marked any injury or Att. Agnes R. Higgs Ernest A. Hitte, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Clark/Executor 8809 Rymer Way, Owings, MD 20736 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 2/18/2011 cemetery, crematory or other place)
Kalas Crematory 1 🔲 Burial 🔰 🗓 Cremation 3 🗆 Removal from State Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur ald 6160 Oxon Hil Rd. Oxon Hill, MD 20745 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and -transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Year Pregnant at time of death signed by the a Id be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 XNo death? 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tes 2 🗓 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The Desirable Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier D0066995 2/17/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

Adedoyin Akintide, M.D. 25500 Point Lookout Rd. Leonardtown, MD 20650

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 13 2011 FEBRUARY Physician/ 11:20 AM GRACE HARRISON Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2X F Months Days Hours MAY 25 MARYLAND T927 83 Director 213-24-3193 Usual Residence of Decede or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 √ Yes 2 □ No CAPITOL HEIGHTS PRINCE GEORGE'S 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20743 7922 BEECHNUT ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married BLACK Maryland 21215-0036 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exar 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT ADMINISTRATOR 2YRS Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 LILLIAN TOLSON GEORGE BLAKE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7922 BEECHNUT ROAD CAPITOL HEIGHTS, MARYLAND 20743 PATRICIA A. HARRISON/DGT. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State RIVERDALE, MARYLAND RIVERDALE CREMATORY 2/19/2011 4 ☐ Donation 5 ☐ Other (Specify) J.B.JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility ture of Furneral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as car inc or respiratory arrest shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 Fetal death Day in the past 12 months? Month Year Other (specify) Pregnant at time of death No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2X No Yes 26. Place of Death (Check only one) 25 Was case referred to medica Be examiner? Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) |요 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of 27. Manner of Dear 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature apo

State Registrar (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 07008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Feb 9 2011 2:15A GERALDINE S. HALL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot 9. Birthplace (State or Foreign Genesis Health Care The Pines Easton
Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** 1 □ M 2**X** F Months Days Hours 09-05-1945 Director MD 214-44-2799 65 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show notified at 1 X Yes 2 □ No Director 28a-f EASTON MD TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examinar of 181 be. UNITED STATES 21601 WASHINGTON ST., APT. 103 1200 S. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Geraldine Hall Baltimore, Maryland 21215-0036 1 □Yes 2 K No Specify: ۵ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **GROCERY** CASHIER 8 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AMELIA MYERS ၉ JOSEPH HARRISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1200 S. WASHINGTON ST., APT. 103, EASTON, MD 21601 IRVING B. HALL, JR. Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 02-11-2011 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
200 S. HARRISON ST., EASTON, MD 21601 HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Brianna M. Tyono Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) signed by the a 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy 1 ☐ Yes 2 🗆 No 1 ☐ Yes 25. Was case referred to ree examiner? 26. Place of Death (Check only one) Be Other: 4 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1. Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number M use of death (Item 23a) (Type, Print) 30. Name and address of person who complete

Registrar
DHMH 17 Rev 1/2001

State

Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:16 AM 2011 HIGHLAND JR. ROBERT MACNEAL February Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Country) New York 8. Date of Birth *(Month, Day, Y*e Jan 16,1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours Min. 1 🛛 M 2 🗆 F 063-28-3106 75 **Director** Usual Residence of Decedent Show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🔼 No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 13136 Manor Drive <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give "natural", Completed 3 Widowed 4 Divorced White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the Sales Representative Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) other traumatic Robert M. Highland Sr. Margaret Kibby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna L. Highland/ Wife Maryland 21771 <u>3136 Manor Drive, Mt.</u> Airy, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or 4 Donation 5 Other (Specify) Stauffer Crematory Inc. 2/19/2011 Frederick, Maryland. 22 Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, Signature Funeral Service P . A. Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Probable Immediate Cause (Final Physician/ DV disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to for se a consequence of ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Dav Pregnant at time of death 2 No the i 9 Unknown g Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Jas page 2 autopsy performed? Yes 2 No 1 🗌 Yes 2 🗀 No Physician: The certificate 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) funeral director, Be Other: Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending After Natural 5 Pending 1 🗌 Yes 2 🗌 No death. hours after death neral Director; A ifiled in by the fi Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Prectigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi DOO 35267 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Manuel Casiano, M.D. 400 West 7th Street, Frederick, Maryland 21701 Year) 32, Registrar's Signature State LORAND ... Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} Physician/ February 2011 Ellery 7:42 Cleary Haynes. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Frederick Calvert Calvert Memorial Hospital 6. Sex 1 X M 2 A F Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 07-18-1931 Wash. Hours 577-38-4597 Director D.C. 79 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ☐ Yes 2 🎇 No Calvert North Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20714 USA 3608 7th Street hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give Black White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify. Completed Year or Dates. 1952-53 White and Mental Hygiene.
is marked other than "natur 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) construction plumber 10 1 and 2 should be filed w f Health and Mental Hygi item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elizabeth Zenns Marguerite Cleary Havnes. Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 7th Street, North Beach, MD Janet E. Thomas, daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of 1 Durial 2 X Cremation 3 Demoval from State 4 Donation 5 Other (Specify) Metropolitan Crematory 2-21-2011 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ a. COMPLICATIONS WEEKS Medical resulting in death) Due to (or as a consequence of) Examiner YFARS THEOSCUERUTIC RDIVATEULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (u) as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No P 5 Other (specify) Pregnant at time of death Month Day Year be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ģ F BRILLATION 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? this certificate has page 2 performed Yes 2 FAILURE 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 HO ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) 30. Name ar 10+ WEIGEL 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Ernest Jagerman Harry 2011 February Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Severna Park 713 Dividing Road 8. Date of Birth (Month, Day, Year)
Tulv 12,1927 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) Country)
Maryland **Funeral** 1 🔀 M 2 🗆 F Months Hours 83 110-20-0615 Director Usual Residence of Deceden 10d. Inside City Limits shov 10h County 10c City Town or Location 10a. State with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Anne Arundel Arnold 1 Yes 2 X No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21012 USA Funeral 465 Broadwater Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Year or Dates. WWII filed within 72 hours after death 14. Race - American Indian 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 ▼ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Flooring Flooring Installer 1 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. Helen E. Crouch 2 Ernest Jagerman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 713 Dividing Road Severna Park, MD 21146 Denise Diedrich / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of February 20a. Method of Disposition 22 cemetery, crematory or other place) 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 2011 MD Veterans Cemetery Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 495 Ritchie Hwy, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of the IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Month 5 Other (specify) the a g Unknown g 🗌 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe Yes rgutu 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Home 4 Nursing Home 5 Residence 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 2ر| After this filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No М Investigation Could not be Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office determined building, etc. (Specify) a Puneral I Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifie 39505 day M.D Name and address of person who completed cause of death (Item 23a) (Type, Print) low, Glan Bun 21061 305 Hospila 1 8 2011 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:40 A M 2511 James Feb Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 😾 M 2 🗆 F Months Hours Min. DEC. 2 1948 WASHINGTON.DC 578-66-0024 62 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1X☐ Yes 2 ☐ No PRINCE GEORGE'S BLADENSBURG MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20710 5408 TAYLOR STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, et-1 Never Married 2 Married þ BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT ENGINEER 11th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ ETHEL B. BUTLER EDWARD E. JONES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5408 TAYLOR STREET BLADENSBURG, MARYLAND 20710 19a. Informant's Name/Relationship (Type, Print) SARA J. BURNS-JONES/WIFE 20c. Location - City or Town, State Method of Disposition 20b. Place of Disposition (Name of Date Burial 2 Cemation 3 Bernoval from State 3/1/2011 CHELTENHAM, MARYLAND VETERANS CEMETERY 4 Donation 5 Other (Specify) eral Service Licensee 22. Name and Address of Facility J. B.JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ uspected PSIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed? Yes 2 No death? 1 ☐ Yes 2 X No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be Hospital 9 Other: 1 Yes 2 🔼 No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 255 Feb 16 2011 MI

Registrar

22 S. Greene St

Battimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Windsor

32. Registrar's Signature

back

Andrew

Thomas

31. Date filed (Month, Day, Year)

FFR 2 2 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02-07-2011 9:00 A M Jenny Frances Knauer Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Accokeek 215 Gingrich Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours 06-02-1931 PA Director 97-28-5235 79 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 XYes 2 No Prince George's Accokeek MD10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20607 215 Gingrich Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. þ 1 Never Married 2 X Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natur ury or other traumatic event, the Medical ury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Private Industry Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irma Philips Davis Knauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Gingrich Dr., Accokeek, MD 20607 Dion Johnson/husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once, 1 🗌 Burial 2 🗆 X remation 3 🗀 Removal from State cemetery, crematory or other place) 02-16-2011 Riverdale, MD Riverdale Crem. 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave., Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Stroke (Cerebral Vascular Accident) Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Mitral Valve Heart Disease Hospital or Attending Physician: The law requires that the death certificate be executed use as the bunal-transit and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ģ Month Day Year Pregnant at time of death 2 should be detached 1 ☐ res ∠ . 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed Yes 2 X No ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 1 ☐ Yes 2 ☐ No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Translation 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After injury X Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) Feb. 15, 2011 D41182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20744 MD8507 Oxon Hill Road, #102, Ft. Felton Anderson, Washington. Date filed (Month, Day, Year, 32. Regi strar's Signature 182011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday)	If Under		If Under	24Hrs. Min.		(MM/DD/YYYY) 9. Bir Foreig	thplace (State or		
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee							neral Servi			
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Division of Vopital or Attending Ph. hours after death. uneral Director: After to y filled in by the funeral	Certification:	Suicide Could not be determined (Specify) residen	ce/d	laycaı	re			Capito	1 Heights	Md.		
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0.1		30. Name and address of person who completed cause of death (Item 23a)	A/ D=1	tim or - C	tro c t	Raltima	TO MIT	7 21222	14			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Amend #20bper FH TT 02/22/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 12, 2011 2:30 P M Norman Foster Kennedy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Prince George's Chever1v . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Hours (Month, Day, Year) 01/10/1927 Washington, 577-30-9956 84 **Director** Usual Residence of Decedent or 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Seat Pleasant Marvland| Prince George's 10e. Street and Number 10g. Citizen of What Country? Funeral 131 69th Street 20743 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1987

X Yes 2 | No 1987

If Yes, Give Retired

Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X XNo Specify. Specify: White 3 M Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 lith and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 10 véars Parts Specialist D.C. National Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Frank James Kennedy Salzman and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other to Sherrie M. Kennedy / Daughter 131 69th Street Seat Pleasant, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 03/4/2011 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. ! Unknown Arlington, Virginia 21. Signature Francial Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA War 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FATAL Physician/ ARRYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner painre due to Jop (i) MultiorAan Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 KNo Certificate: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mukemi) Andella, mD 1899200C 13 111 CANI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 👡 🕥 3000 Hospital Dr. Cheverly, MD 20785 andelia lukemil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 FEB. Physician/ 11:30 A M 11, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1313 Motter Ave./ Apt. Frederick Frederick If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
Sept. 29, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 **X** M 2 □ F Months Days Hours Country) Kentucky Sept. Director 232-42-0730 85 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Frederick Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21701 United States 1313 Motter Avenue, Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Completed by Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Assembly Line Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Chloe Kennedy Elliot Kennedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau Walkersville, Maryland 122 Capricorn Road Carlene Sample / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition February 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Wayland, Massachusetts Lakeview Cemetery 18, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation ⊒ Acciden ⊒ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of cer 29d, Date signed (Month, Day, Year) February 14, 2011 D37197 30. Name and address of person who completed cause of death (Item 23a) (Type ()+

State Registrar 32. Registrar's Signature

			Please	• Type or Print in State of Maryla				_	_				
			1 - State Registrar Amend#1per	funeralhome2/					Reg. No.	0/01/			
	Physicia Medi	cal	1. Decedent's Name (First, Middle, La	F-	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	azior	OR	2. Date of De Month	1 Day 2 Year	3. Time of Death			
	Exami	ner	4a. Facility Name (if not institution, give 16309 Marsham				or Location of Deat r Marlboro	h	4c. County of Dec Prince (
	Funeral Director		5. Social Security Number 6. S 358 46 8559 1 Usual Residence of Decedent	7. Age (<i>lin yrs.</i> 57	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da Aug 16,	th y, Year) 9. B 1953 C	irthplace (State or Foreign ountry)			
	Maryland 28a-f show otified at	Funeral Director	10a. State 10b. County	eorge's	ity, Town or Lo	cation Mar1boro				10d. Inside City Limits 1 Yes 2 No			
	with the	eral Di	10e. Street and Number 16309 Marsham D	rive		10f. Zip Code 207	72	1		. Citizen of What Country? United States			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>ک</u>	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	l l	Vas Decedent of I f Yes, specify Cub ☐ Yes 2XXN	Hispanic Origin? (Sean, Mexican, Puerlos Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify:					
21215-0036	vithin 72 hou jiene. er than "natu the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12) 12		(Give I life. De	dent's Usual Occu kind of work done O NOT use retired Force	during most of wo	rking	16b. Kind of Business Military	s Industry			
Baltimore, Maryland 2	ld be filed v Mental Hyg ar ked othe atic event,	To Be	17. Father's Name (First, Middle, Last) Martin Kazior				1	me (First, Middle, y Kazior	Maiden Surname)				
, Mar	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (7 Marilene S. Kazior						r, City or Town, State, Z	ip Code)			
more	Page 1 an nent of He ant: If iten ury or oth	1-	20a. Method of Disposition 1 ☐ Burial 2XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Dispo cemetery, crem e Cremat o	sition (Name of natory or other pla	:	Date 16, 2011	20c. Location - City o	r Town, State			
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	1 100	533 22	. Name and Addre		Funeral H		Old Alexandria			
	Physician/ Medical Examiner	ier	23a. Part 1. Enter the disease, or shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	plications that caused the dealer cause on each line. a. Due to (or as a consect b. Due to (or as a c	juence of):	er the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onsertand Death			
09	cate be executed physician and sthe burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consected d.	· · · · · · · · · · · · · · · · · · ·	_							
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ls, P.O.	requires that been signed b		Part II. Other significant conditions c	ontributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.		obacco use contribute t Yes 2 □ No 3 □ F	o the cause of death? Probably 4 Dunknown			
Division of Vital Records,	s ician: The law requ s certificate has beer lirector, page 2 shou	Completed by							rmed? prior to death?	utopsy findings available completion of cause of			
/ital	sician: certific irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐		Oth	low.	ce of Death (Check only one)					
on of \	Attending Physician: 1 sr death. ector: After this certifics by the funeral director, p	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	4 □ Nursing F ry at k? Yes 2 □ No		ence 6 Other (Specow injury occurred	pify)						
Division			3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	et, factory, office			if. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or within 24 hours afte for the Funeral Direction properties of the funeral Direction filled in the following the filled in the following filled in the follo	Medical	(Check 2 L Medical Exami	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of m	n and/or investi	gation, in my opini	on, death occurred	at the time, date ar	nd place, and due to the	cause(s) and manner stated.			
	Nith With Con		29b. Signature and title of certifier	a) N/P		29c. Licens			29d. Date signed (Mont				
2	BIST		30. Name and address of person who of	completed cause of death (Iten	1 23a) (Type, Pi	ler,44	SDEFE	NSE H	KUUAPW	POLISH DZ140			
	Star Registra	_	31. Date filed (Month, Day, Year) FEB 18 2	32. Registrar's Signa	ture .	all							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 12 2011 11:50 A M DOMINGOS KIPETTE ANTONIO Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY Social Security Number Sex 1 🛣 M 2 🗆 9. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth Funeral Days Months Hours AUGUSTV. 6 ⁾1948 AFRICA Director 62 254-39-9791 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Yes 2 No PRINCE GEORGE'S DISTRICT HEIGHTS MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a USA RITCHBORO ROAD 20747 8569 items ? hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 24 No Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 BLACK 1 Yes 2 No If Yes Give Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates al Hygiene. d other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED PRIVATE 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental be ROSA J. SEBASTIAO DOMINGOS G. KIPETTE and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8569 RITCHBORO ROAD DISTRICT HEIGHTS, MARYLAND 20747 AURORA E. KIPETTE/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 2/18/2011 BRENTWOOD, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral San e Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, HYPERTENSION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPERLIPIDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) CARDIAC VASCULAR DISEASE Cause (Disease or linjury that initiated events ATHEROSCLEROSIS and burial-tran Due to (or as a consequence of resulting in death) Last physician Physician/Medical PERIPHERAL VASCULAR DISEASE The law requires that the death certificate be as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ P in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 X No 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director; 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Inpatient 2 X ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiners On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKE ARBOIZ WAY \$202 MITCHELVIUE. 10274

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2 Catherine Bell Littleton 2011 7:15 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 StF (Month, Day, Director 218-20-4328 84 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10420 Azalea Rd. 21811 USA Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuany injury or other traumatic event, the Medical. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cargill Company 8 Chicken Vaccinator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Daisey Dennis Arthur Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Berlin, MD 21811 10420 Azalea Rd., Tammy Jarman / daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 🗌 Cremation 3 🗌 Removal from State Dale Cemetery 2/23/2011 Whaleyville, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to him reduce cause. Enter Underlying Cause (Disease or linjury Dain to (or as a punswarence of) physician and the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 1 Yes 2 No cate has been signed by tage 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2. No certificate l Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical of Vital Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27, Manner of Death Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide
Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certify g Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Med al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Ceytifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Registrar's Signature

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FEB 2 2 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\) For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 19 Physician/ 4:55 AM Mary Rose Laroche 2011 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Berlin Nursing Home If Under 1 Year | If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 📭 Davs Hours 7/30/1919 Country) Vn 91 Director 007-10-3902 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral tems 23a USA 21811 21 Brittany Lane 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. Examiner Black, White, etc. or. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🙀 No If Yes, Give 21215-0036 1 ☐ Yes 2 No Specify: Specify: "natural", 3 □xWidowed 4 □ Divorced white Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) US Government Welder Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine St. Pierre Joseph Ouellette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Lane, Berlin, MD 21811 Department of Health Important: If item 27 Maurice Constant / son injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State State Crem. 2/21/2011 Millsboro, DE 4 Donation 5 Other (Specify) 21. Sign to e of Funeral Service License 22. Name and Address of Facility Burbage Funeral Home William St., Berlin, MD 21811 08 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner colonary Gequentiary list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 XNo Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown s been signed by the should be detach Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed?

1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 XNursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA မြ this (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. XNatural 5 Pending 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or furd a 29b. Sian nd title of certifier 29c. License number R 135131 ennie February 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21811 9715 Healthway Dr, Berlin, MD CRNP Pennie Savage, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Darke Registrar

JAROCHE, MARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician/ James Edward Lynch A^{M} :15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin 110 Cedar Ave. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) 1 ⊠ M 2 □ F Months Days Hours Min 86 Director 215-20-4829 Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director Berlin MD Worcester 1 Types 2 No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 21811 USA 110 Cedar Ave. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 1. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 No within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Building Contractor permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Lee Lynch Katie Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Lynch / wife Berlin MD 21811 110 Cedar Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 2/24/2011 Bishopville MD 4 Donation 5 Dother (Specify) Bishopville Cem. 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Furnial Service Licensee 108 William St., Berlin MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SAIZCOMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Elter Uncertying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit law requires that the death certificate be executed that initiated events ing physician a e as the burial-t resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has I autonsy Hospital or Attending Physician: The 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cy. ifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) nd title of gertifier 29b. Signature 29d. Date signed (Month. Day. Year) 122 0/2 201

State Registrar 30. Name and addr

Glehn Arzadon

31. Date filed (Month, Day, Year)

Healthway

Drive Berlin, MD 21811

ss of person who completed cause of death (Item 23a) (Type, Print)

MD 9711

32. Registrar's Signature

Theodore Elroy		1- For State	of Maryland /	Depa	artment <i>tificate</i>	of Hea	alth an	d Men	tal Hy	/giene	۷ ۷		07022		
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Las		-		0, 500			П	2. Date of De		'ear	3. Time of Death		
Medical Exami	ner	Theodore 4a. Facility Name (if not institution, given	naw	Ab City	Town or	r Location o	of Death	February	Day Y 17, 2011 4c. Count		1852 hrs				
		11300 Riverview Road	e street and mariour)				Washi		DCG(II			Georg			
Funeral		5. Social Security Number 6. Sec	_		ast birthday)		der 1 Yea		er 24Hrs.	-4		C	rthplace (State or		
Director			M 2 F 65	5	,	Yrs. Mon	ths Day	s Hours	Min.	July	25,1945	C	ountry) Jamaica		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits		
und show	۲	Maryland Prince	George	For	t Wash	ningto	on						1 Yes 2 No		
Maryla r 28a-f	Director	10e. Street and Number			ip Code				10g. Citizen of \	What Cou	intry?				
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	- 1	11300 Riverview	e [13]		0744	enanic Orio	nin? / Sn	ecify Yes or N	USA	ce - Ame	rican Indian, Black,				
leath w	Funera	1 Never Married 2 X Married	12. Was Decedent B Armed Forces? 1 Yes 2	X No		If Yes, spec	cify Cubai	n, Mexican,	Puerto	Rican, etc.)	Wh	nite, etc.			
after o	by F		If Yes, Give Year or Dates:			Yes						,: Bla			
hours "natur		15. Decedent's Education (Specify of Elementary/Secondary (0-12)	16a. Deced during	dent's Usua g most of w					16b. Kind of I	Business	/Industry				
036 thin 73 ne.	Completed	Ziomonal yrososmasi y (oʻtz)	College (1-4 or 5- 4	,	Inst	ırance	e Age	ent			Nation	nwide	e Insurance		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	ပိ	17. Father's Name (First, Middle, Last Maxmillan Lan	oshaw				Ī	18.Mother		(First, Middle Lucas	, Maiden Surnan	ne)			
2121 ild be f Mental marke event,	To Be	19a. Informant's Name/Relationship (1			19b. Mai	ilina Addres	ss (Stree				umber, City or To	own State	a Zip Code)		
MD de 2 shoulth and 1 is 1 i		Dorothy N. Langs				-	•				shingtor				
s l and fi Healt fi teen	Ì	20a. Method of Disposition 1 Burial 2 X Cremation 3	Removal from Stat		Place of Disp rematory or					Date	20c. Location	n - City o	Town, State		
Baltimore, pernit. Pages I at Department of Her Important: If ite		4 Donation 5 Other Specify	alas (_			20/2011 Edgewate			-				
Ball permit Depart Impor		21. Signature of Funeral Service Licer	nseel		6	2. Name an 5160 (nd Addres: Oxon	s of Facility Hill	Rd.	rge P. Oxon 1	Kalas H Hill, MI	uner) 207	ral Home 745		
Physician	1	233 Part I. Enter the disease, or comp failure. List only one cause on e		he death.	Do not ente	er the mode	of dying,	, such as ca	ardiac or	respiratory a	rrest, shock, or h	neart	Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease a.	Contact Gunsho			Chest an	d Abdo	men					Death		
		or condition resulting in death) Due to (or as a consequence of): b.													
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
=	Examiner														
e executed ian and ial - transit	ical E	d.	1 ****										 		
50, te be ex tysiciar burial	ledi	UNPENDED	AMENDED 23c. If yes, outcome	e of pregr	ancy						23d. Date	of deliver	<u></u>		
6876 ertifica ding ph	a	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2	Fetal deatl	h 3	Ectopic	pregnar	псу	Month		Day Year		
Box 68760, e death certificate be the attending physic ed for use as the bur	hysici	1 Yes 2 No 9 Unknown	Pregnant at to	ime of dea	ath 5	Other (Sp	ecify)								
.O. Box 68760, that the death certificate be need by the attending physic detached for use as the burn	<u>о</u> .	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of deat					
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by										es 2 V No		bably 4 Unknown		
cord law req has bee	Completed	24a, Was an 24b, W autopsy performed?											utopsy findings available completion of cause of		
Rec: The ficate f, page		25, Was case referred to medical					DC Diese	e of Death ((Ohaalaa	1 ✓ Yes		1 🗸 Y	es 2 No		
Vital Reconstant The lample of	o Be		Hospital: 1 Inpatien	t 2 🗌	ER/Outpatie	ent 3		O#			Residence 6	✓ Othe	r: Scene		
n of ding Ph	-1	27. Manner of Death	28a. Date of Injury FOUND:	y ar)	28b. Time o	of Injury		ry at Work	I	28d. Describe how injury occurred Subject shot self					
Sion Attend death. ector:	catic	1 Natural 5 Pending Investigation Peb 17, 2011 1830 hrs 1 Yes 2 N N N N N N N N N N N N N N N N N N										hor or D	ural Route Number, City		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn		29a. Certifier (Check only 1 Certifying Physic	ian: To the best of my	knowledg											
To I	Medical	29b. Signature and title of certifier	and manner stated.							-			nth, Day, Year)		
0		1//	1				O.C.M.E. February 18, 2011								
OCMED		30. Name and address of person who Mary G. Rippie MD. De	completed cause of de puty Chief Medic		,	00 W. B	altimore	e Street,	Baltim	ore, MD 2	21223				
		31. Date filed (Month, Day, Year)	32. Registrar	s pignatu											
Regist	ıcΓ	FEB 2 2 2011 Lens	~~ N. M												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ebruary 2011 Clinton Leon Latham 12:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3767 Primrose Ct harles Waldorf Sex 1 X M 2 □ F . Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 10, Days Hours **Director** 69 1941 Washington, D.C. 215-38-4758 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Charles Waldorf 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Page 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene. fant. If item 27 is marked other than "natural", or items 23a or jury or other traumatic event, the Medical Examiner must be 1 Funeral 3767 Primrose Court 20602 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes. Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Safe Master |Federal Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Alfred Frizzel Marie Woodvard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr <u>Joan Latham/ Wife</u> Primrose Ct. Waldorf, Maryland 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Huntt Crematory** Feb. 19, 2011 Waldorf, MD. 22. Name and Address of Facility Huntt Funeral Home . Signature of Funeral Service Licensee Moliaa Old Washington Rd. Waldorf. 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician, disease or condition Medical resulting in death) Examiner B Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year 1 Yes 2 9 Unknown 2 🗌 No g 🗌 Unknown detached been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cate has been siç ; page 2 should b Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death?
1 Yes 2 No after death.

Director; After this certificate! Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Certificate: To 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) in'by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work?
1 Yes 2 No 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of my knowledge, examined the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. Lice 29d. Date signed (Month. Day, Yelar)

State Registrar 31. Date filed (Month, Day, Year)

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Ph /ledical E	ysicia xami	an/	Registrar 1. Decedent's Name (First, Middl $E11wood$ A	e,Last)	Lewis	Jr.			2	2. Date of Dea Month February	ith		me of Death 221 hrs		
there of			4a. Facility Name (if not institution 4225 Robinson Road	n, give street and nu	imber)		4b. City, Town, o		of Death		4c. County of Calvert	Death			
	neral ector		5. Social Security Number	6. Sex		last birthday)	If Under 1 Ye		Min.	1 _		Foreign			
5			214-58-4212 Usual Residence of Decedent	1 X M 2 F	5					08/01/	1952		ngton, DC		
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2	other thao "natural", the Medical Examioer	leted	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1		during n	nt's Usual Occup nost of working lit				16b. Kind of Busi				
od wil	other than	Completed	12 17. Father's Name (First, Middle,	Last)		sale	sman	18.Mother	s Name (First, Middle,	automob Maiden Surname)	ile d	ealership		
21215 uld be file Mental H	arked veot,	Be	Ellwood Aloysius Lewis, Sr. Barbara Gay Ofens												
, MD and 2 shot	em 27 is raumati		Susan M. Lewis, wife 3310 Solomons Island Rd., Huntingtow 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location-									MD City or Town,	20639 State		
Baltimore, permit. Pages 1 an Department of Hea	Important: If item 27 is marked iojury or other traumatic eveot,	17-7	1 X Burial 2 Cremation 4 Donation 5 Other Sp	/	om State M	orematory or of Vetera	her place)				Che1ten				
Balti permit. Departr	Import		21. Signature of Funeral Service	7 Doe	ans I	83	Name and Addre	Harmon	Rau. v La	sch Fu	neral Hom ings, MD	ne, P.	A. 6		
Physi		8	23a. Part I. Enter the disease, or failure. List only one cause	on each line.		th. Do not enter	the mode of dying	g, such as ca	ardiac or i	respiratory arr	est, shock, or hear	t App	proximate Interval tween Onset and Death		
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~ š	ysician a burial - 1	ledical	UNPENDED IF FEMALE:	AMENDED 23c If yes	outcome of pre	egnancy					23d. Date of d	elivery			
Box 6876(attending physician and or use as the burial - transit		23b. Was decedent pregnant in the past 12 months?	1 Live b		2 Fe	etal death 3	Ectopic	pregnan	су	Month	Day	Year		
	y the	Physi	Part II. Other significant condit	ons contributing to		resulting in the	underlying cause	given in Pa	irt I.	23e. Did t	obacco use contrib	ute to the ca	use of death?		
Is, P.O.	is been signed be should be deta	ted by	_						_	1 Ye	s 2 No 3		4 V Unknown findings available		
of Vital Records, ng Physiciao: The law require	, h	Completed			or to comple ath? Yes	etion of cause of									
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Division tal or Atteodii 13 after death.	Director: I in by the	Certification:	2 Accident Inver	d not be 28e. Place	e of Injury - At	home, farm, stre				28f. Location (Street and Number	or Rural Ro	oute Number, City		
Hospi	Fuoeral tely fille		29a. Certifier 1 Certifying P	(Specify) nysician: To the bes	st of my knowle	edge, death occu	rred at the time,	date and pla	ice, and d	lue to the cau	se(s) and manner a	is stated.			
To the	To the Fuc	Medical	one) 2 Medical Example 29b. Signature and title of certific	miner: On the basis and manner s	of examination tated.	and/or investiga		on, death oc	curred at	the time, date	and place, and du				
			Pot a	ROL			0.0	.M.E.			February 9,	2011			
RW 4	+1		30. Name and address of person Patricia Aronica-Polla	k MD. Assista	ant Medica	l Examiner	900 W. Balt	imore Str	eet, Ba	ıltimore, M	D 21223				
	St Regis	ate	31. Date filed (Month, Cer. Year)	8 2011 32. Rg	gistrar's Signa	ature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:38a M Maurice F. Mwrphu February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomeru Holy Cross Hospital g. Birthplace (State or Foreign Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 **Funeral** 1 X M 2 🗆 Months Country) Wisconsin 1074 44 191 9 91 Director 394-10-6333 Jsual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location hours after death with the Maryland 10a. State Director 1 Yes 2 X No Burtonsville Maryland Montgomery 10e. Street and Number 10g, Citizen of What Country? Funeral U.S.A. 20866 14601 Perrywood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give Specify: White. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Department of the Navy 4 and Mental Hygier is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Albert Murphy Kathrun C. Oster permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14601 Perrywood Drive, Burtonsville, MD 20866 Marthe Chausse Murphy - Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 02/16/2011 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee -11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Small Bowel Obstruction Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Dav Other (specify) Pregnant at time of death 2 No signed by the a d be detached f 1 L Yes 2 L 9 D Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

*To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗓 No ည 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 09, 2011 D60826

Registrar
DHMH 17 Rev 7/2009

State

1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kshama Garg,
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February Physician/ Maybelle Waldman Muir 6:30 A. M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Angel Garden Assisted Living Montgomery Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Day, Year) 1 2,1909 Washington, Months Days 1 M 2 X F 579-42-7644 101 Director March Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and it if item 27.7 is marked of other than "natural", or items 23a or 28a-f show ant: If item 27.7 is marked of other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director MD Montgomery Rockville 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4101 Bel Pre Road 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferdinand Waldman Flora Fendner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gordon Waldman Muir/Son 8919 Fairview Road, Silver Spring, MD 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February 11 cemetary crematory or other place).
Geo. Wash. University
Medical Center Department of 1 Durial 2 Cremation 3 Removal from State Important: If any injury or Washington, D.C. 2011 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 uta 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE Ph_sician/ MYCHARRIAL disease or condition resulting in death) LINUTES Medical Due to (or as a consequence of) Examiner Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consectional of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed The second and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 tor: After this certificate has been signed by the attending p the funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnapt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month Day Year 5 Other (specify) Pregnant at time of death 9 🗌 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 🗌 Yes 2 🖼 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) EREC) F Hospital 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manne Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred * Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Vertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ROSENBAUM

32 Registrar's Signatu

Da 9834

3720 FARRAGUT AVE. KENSENGTON, MD 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 2914 4-6-11 yt State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 11:00 a.M MacPherson Etta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Lexington Park 46171 Leesa Court Social Security Number 012-72-3494 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 🖾 F Months Days Hours 0371071957 -72**-**3494 53 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 Yes 2 K No St. Mary's Lexington Park Maryland 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 46171 Leesa Court 20653 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 K No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Ε. Derry John Summers, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau Leesa Ct., Lexington Park, MD 20653 <u>Duncan MacPherson/Spouse</u> 46171 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 02/24/2011 St. Leonard, MD 4 Donation 5 Other (Specify) Waters Memorial UMC Signature of Funeral Service Licen Danielle Ward M01403 Brinsfield-Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrest Cardiorespiraton Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Possible MI Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes ∠ y 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\bar{\mathbf{X}} \end{array} \) Residence \(6 \) Other (Specify) 2 X No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avani D. Shah, M.D. 22650 Cedar Lane Ct., Leonardtown, MD 20650 31. Date filed (Month, Day, Year) FEB 2 3 2011 32. Registrar's Signature

State

Registrar

ack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1500 February 2011 Medical Maxine McNeal 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Surburban Hospital Bethesda Montgomery 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 🗆 M 2 🖰 F Days Hours Dec. 6. Î951 249-96-5979 59 Director Florence, S.C. Usual Residence of Decedent show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Yes 2 No Maryland Montgomery **Bethesda** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5721 Grovenor Ln. 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any fijury or other traumatic event, the Menand pines. Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ear1 Frierson Odessa McNeal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2270 Astoria Circle Apt. 306 Herndon, Va. 20170 Tara M. Davis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 2/28/2011 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope, P.A.
5538 Marlboro Pike/ Forestville, MD. 21. Signature of Funeral Service Lig 20747 June 01085 Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular Accident Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner **Encephalopathy** Sequentially list conditions, Examine fl arry, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Diabetes Mellitus Insulin Dependant Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Arter this certificate has been signe funeral director, page 2 should be u 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 😾 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify, မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 Yes 2 🗌 No 24 hours after death Accident Investigation completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🔾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and title of certific 29¢. License number 29d, Date signed (Month, Day, Year) February 15, 2011 D53691 20852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REDDY, MD. 3200 TOWER OAKS BLVD. SUITE#110, ROCKVILLE, MD. PULIMAMIDY AJAY 31. Date filed (Month, Day, Year FEB 1 7 2011 Back Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 07 9-00 PM **Physician** Zoil MARY LYDIA McALLISTER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** AGNES HOSPITAL BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) 07-23-1926 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1□ M 2□ F Maryland Yrs. 212-26-2836 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Metalla Hygiene. Integrating it fem 23a or 28a-f show Important; if them 23 marked other than "ratural" or items 23a or 28a-f show any injury or other traumatic event, It is Medical Extraining from the refined at 1 ∏Yes 2 ☐ No Director Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 21801 875 Victoria Park Apt. 313 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify. 2 3 ☐ Widowed 4 🔀 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian M. Anderson Robeck Dr. Walter M. Robeck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1004 Marley Manor Drive, Salisbury, Md. Paige Marriner Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02-11-2011 Princess Anne, Md. Perry Hawkin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINMAN FUNERAL HOME 11673 Somerset Ave. M00295 • Princess Anne, Md. 21853 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FEWDAYS iate Cause (Final **Physician** die se or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) 9 Unknown certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 🗷 No director, 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours after

To the Funeral Dire

completely filled in b 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) State FEB 18 2011 Registrar

29b. Signature and title of certifier

MATBEN AWAN 10796 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

29c. License number

HICKIRY RIDGE RD

Doc62634

29d. Date signed (Month, Day, Year)

FEB 14, 2011

COLUMBIA MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Day 2258PM MARY В. MORRIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Cheverly Prince Georges Hospital 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 927 1 M 2 X F Months Hours Director 231-26-3919 84 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 T No MD Prince Georges Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA #201 20706 8413 Hamlin St. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give Specify. Completed 3 X Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home should be filed with and Mental Hygien rs marked other th 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Estes Bates Ethel Bishop 1 and 2 should bet Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3006 Brightseat Rd. #103 Lanham, Md 20706 Ella M. Grimes-daughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem 2-23-2011 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service License Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate CARDIAC ARRHYTHMIA Immediate Cause (Final Physician/ TATAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause, Enter Underlying Exami Cause (Disease or linjury that initiated events burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day for Month 5 Other (specify) Pregnant at time of death the þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA 1 Yes မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one 29b. Signature 29c. License number D63688 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar DAVIS

GRIFFIN

31. Date filed (Month, Day,

HOSPITAL

Registrar's Signature

CHEVERLY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ 2011 4:15 AMSharon M. Moore Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's 8. Date of Birth (Month, Day, Year Mt. Rainier 3204 Perry Street Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖾 F Months Days Hours 1956 North Carolina 54 Director 577-76-9911 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1X Yes 2 No Prince George's Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20712 USA 3204 Perry Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 r.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nellie Eason Melvin Sanders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20712 Mt Rainier, Md Julie Sanders / Daughter 3204 Perry St. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/24/2011 Brentwood, Md 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licenseereta ffrances 20722 3401 Bladensburg Rd. Brentwood, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cervical Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒No Month Day Year Pregnant at time of death 1 L res 2 L 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? this certificate 2 🔀 No 1 Yes 2 No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work?
1 Yes 2 No 5 Pending injury X Natural ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) within 24 hours a Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

Ivan Zama, M.D.
31. Date filed (Month, Day, Year)
FEB 2 2 2011

Suite 200

of person who completed cause of death (Item 23a) (Type, Print)

9200 Basil Court

32. Registr r's Sign

0102

Largo, Md

20774

2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type o											gible.	
		1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. N2 0 1 1												Nava-	07032	
		Decedent's Name	e (First, Middl	e, Last)								2. Date of	Death		.,	3. Time of Death
Physicia Medic	PATRICIA A. MIDDLETON FEBRUARI 17 2011 3:													3:03P M		
Examin		4a. Facility Name (if not institution, give street and number) PRINCE GEORGE'S HOSPITAL 4b. City, Town, or Location of Death CHEVERLY														CORGE'S
Funeral Director		5. Social Security No. 001-34-3		6. Sex 1 M 2 X	7. Age	(In yrs. le	ast birthda Yrs	Mont	hs Days	If Under	er 24 Hrs. Min.	8. Date of (Month, AUG.	Birth Day Ye 27	^{ar)} 944		place (State or Foreign HAMPSHIRE
ld now at	ų.	Usual Residence of 10a. State	Decedent 10b. County	,		10c. City	y, Town or	Location			·					10d. Inside City Limits
arylar a-fsh	ecto	MD		E GEORGE			•		EIGHTS	2						1 kg Yes 2 □ No
the M	Ω̈́	10e. Street and Num		E GLORGE		111.	11010		Zip Code				10g	. Citizen of	What Cou	intry?
s 23a	Funeral Director	713 59th	AVENU	E					20743					USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M dical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marri 3 ▼ Widowed		rried 1 🗆 Ye	Forces? es 2 XN Give		S. 1		cedent of H pecify Cuba s 2 X No			ecify Yes or N Rican, etc.)	No-	ican Indian, etc. HITE		
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uld be d Men marke natic	-													0 7.		
2 sho Ith an 27 is i		19a. Informant's Name/Relationship (Type, Print) LAVINIA P. MIDDLETON/DGT. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5106 EVERGREEN BELLAIRE, TEXAS 77401												Code)		
1 and of Hea item other		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State												Town, State		
Page nent c ant: If ury or		4 Donation 5 Other (Specify) LINCOLN CEMETERY 2/23/2011 SUITLAND, MARYLANI														
permit. Departr Importa any inji		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND														
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Physician/ Medical Examiner	ner	shock, or hear Immediate Cause (I disease or condition resulting in death) Sequentially list continuous and the continuous and	rt failure. List Final n	only one suse on	to (or a	conse tu	ionce in	ten	3	The state of the s	ga	nt	ja	de	ne	Interval Between Onset and Death
ficate be executed g physician and as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.														
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici to the Luneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	F FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 Yes Yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown										23d. Date of delivery Month Day Year				
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sician: The la certificate ha irector, page 2	Be (25. Was case referre examiner?	ed to medical	Hannitali					_		eath <i>(Chec</i>	k only one)		1		
Physicia this cert ral direct	욘	1 Yes 2 2 27, Manner of De th	No		☐ Inpatie		ER/Outpa	atient 3		4 📖	Nursing He	ome 5 R				fy)
ttending I death. tor: After the funer	Certificate:	1 Natural 2 Accident 3 Suicide	5 Pendi	ng (M igation	onth, Day,	Year)	inju	M M		y at (? Yes 2	□ No	28d. Describ				at Davida Museum
To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the		4 Homicide	detern	bui	lding, eťc.	(Specify	')		tory, office			City or	Town, S	itate)		al Route Number,
Hosp 24 ho Fune leted f	Medical		Medical I	Physician: To the Examiner: On the I	oasis of ex	amination	n and/or in	vestigation	, in my opini	on, death	occurred a	it the time, da	ite and p	lace, and d	lue to the c	ause(s) and manner stated
To the within To the Comple	Σ	only one) 3 29b. Signature and t			, lo the b		y Kilowieu		29c. License			ce, and due to		. Date sign		
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Bar		30. Name and address	ess of person	who completed ca	ause of de	ath (Item	23a) (Typ	pe, Print)	1/	RO	The	ILRI	1/	mo	20	785
Stat Registra		31. Date filed (Month		32	. Registrar	's Signat	ture					/				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-01056 State of Maryland / Department of Health and Mental Hygiene Patrick Kelley Mullikin 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 7, 2011 0737 hrs Medical Examiner PATRICK KELLY MULLIKIN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Talbot McDaniel 8612 Tilghman Island Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours Min. Director 217-94-5745 04/09/1964 Country) MD 46 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 1 X Yes 2 No EASTON TALBOT MD death with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 UNITED STATES 103 CHOPTANK AVENUE 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married 2 Married 1 X Yes Specify: WHITE 1 Yes 2 X No specify. 4 X Divorced If Yes. Give Year 3 Widowed ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 21215-0036 CARETAKER PROPERTY MANAGEMENT es 1 and 2 should be filed within of Health and Mental Hygiene.

If item 27 is marked other th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed VIRGINIA JANE SHERWOOD LOUIS EDWARD MULLIKIN 8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 29316 HICKORY RIDGE ROAD, EASTON, MD LOUIS E. MULLIKIN/FATHER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition timore, 1 X Burial 2 Cremation 3 Removal from State 02/14/2011 EASTON, MD SPRING HILL CEMETERY 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD MERCERON 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Contact Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): and d cian/Medical physician a UNPENDED AMENDED Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IE EEMALE 3b. Was decedent pregnant in the Day Yea 2 Fetal death 3 Ectopic pregnancy Month attending | For use as tl Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 Unknown icate has been signed by the att page 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0 1 Yes 2 No 3 Probably 4 Unknown Š Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of certificate has performed? death? 1 🗸 Yes 2 No ✓ Yes 2 No 25 Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi director, of Vital Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA No 1 V Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work 27. Manner of Death Subject shot self FOUND: Natural 1 Yes 2 ✔ No Division 5 Pending Director: Feb 7, 2011 0730 hrs Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 V Suicide or Town, State) 8612 Tilghman Island Road, McDaniel, MD determined (Specify) Farm Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie 29c. License number February 8, 2011 O.C.M.E.

3+ VA

Assistant Medical Examiner Laron Locke MD. 31. Date filed (i pre Par Year) 201 State

Registrar's Signate

ack

900 W. Baltimore Street, Baltimore, MD 21223

even

Name and address of person who completed cause of death (Item 23a)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February George William McComas 2011 Medical 7:30 p M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15 Oak Street Cambridge Dorchester 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Aug. 17, Year 1927 Washington, DC Days 169-20-5640 Months **Director** 83 Usual Residence of Decedent 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits MD Dorchester Cambridge 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Oak Street 21613 USA or items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Yes 2 No Black, White, etc. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced WWII Completed Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Meagnes, once. Elementary/Seconday (0-12) College (1-4 or 5+) owner/operator fuel distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Gough McComas Jr. Martha Elizabeth Neely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George W. McComas Jr. son 15 Oak St., Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 2/17/11 Delmar, DE 21. Signatum of Funeral Service Licenses 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Vascular Vicens Physician/ disease or condition resulting in death) 14000 Medical Examiner 4ears Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, completed filled in by the funeral director, page 2 should 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician:] within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurge Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

title of certifier

29c. License number

29d. Date signed (Month. Day Year) 29b. Signat Front Centre Blod, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CBrandon 31. Date filed (Month, Day, Year) FEB 17 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ I3. Dean Chappell Murrell Ruth 2011 February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year April 15, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛛 F Tennessee Director 1927 412-32-6439 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Frederick <u>Maryland</u> Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21702 United States 8414 Rocky Springs Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 😾 Widowed 4 🗆 Divorced Completed 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wallace Chappell ್ತ Minnie Boshears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Morse / Daughter 8414 Rocky Springs Road Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State cemetery, crematory or other place) February 15, 2011 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CLOSTRIDINM DIFFICLE Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ≥ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a, Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral D Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatu title of certifie 00062223 February 15, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) FLEIBUCE, MD 21702 PRAYERN BOLARUM 196TJDLIVE

8:30

10d. Inside City Limits

White

Onset and Death

SHIND M

1 🗆 Yes 2 🔀 No

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature.

1 - For State Registrar

Physi	cian	1. Decedent's Name (First, Middle	e, Last)						Month	Day Year	3. Time of Death
/Med		Shirley	Eliza		Me	cGill			bruary		5:55 A ^M
Exam	iner	4a. Facility Name (If not institution	_	mber)		4b. City, Town, o		of Death		4c. County of Dea	
di .		22115 Pikeside				Smiths	_			Washir	
Funera		5. Social Security Number	6. Sex 1 ☐ M 2 X F	7. Age (In yrs.		nday) If Under 1 Year Months Days	Hours Hours	Min.	Date of Birth (Month, Day,)	Year) C	thplace (State or Foreign ountry)
Directo	or	213-09-9020		94	T	18.		Se	pt. 26	, 1916 M	ary1and
and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	v. Town	or Location					10d. Inside City Limits
laryla sho	5										1 □Yes 21 No
he M	Director	MD Washi	ngton	Sm	iths	burg			10	g. Citizen of What Co	
vith t	ä	10e. Street and Number	_			10f. Zip Code			109		Juntry ?
ath v	ra	22115 Pikeside			0	21783			V N.	U.S.A.	- do- on the state of
er de	Funeral	11. Marital Status	Armed Fo	edent Ever in U. prces?	5.	 Was Decedent of F If Yes, specify Cub 	an, Mexica	in, Puerto Rica	n, etc.)	14. Race - Am Black, Whit	
rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Yes Gi	ve Kilvo		1 □Yes 2 X No	Specify	/ :		Specify: Wh	nite
filled within 72 hours after death with the Maryland Hygiene. The Hygiene wither than "natural", or Items 23a or 28a-f show ent, the Medical Exeminat must be redified at	eq		nt's Education		16a.	Decedent's Usual Occup	oation		16	6b. Kind of Business	
in 72 in 72 in 4	plet	(Specify only highe	st grade completed)		} '	Give kind of work done life. DO NOT use retire	during mo: d)	st of working	1		
with giene	Completed	Elementary/Secondary (0-12)	College (1	1-40r 5+)	Нот	nemaker				Domestic	
Hygothe ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Moth	ner's Name (Fi	rst, Middle, Ma	aiden Surname)	
ld be fenta ked	10 B	John Willman					Je	nnie H	aynes		
shound N	-	19a. Informant's Name/Relations	ship (Type. Print)		19b.	Mailing Address (Street	and Numb	ber or Rural Ro	oute Number, (City or Town, State,	Zip Code)
nd 2 alth a 27 Is		Linda Turnbull			22	ll5 Pikesid	e Dr.	. Smit	hsburg.	MD 2178	33
item othe		20a. Method of Disposition		20b. F		Disposition (Name of crematory or other plan		Date		Oc. Location - City or	
age ento		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		g crematory or other plat aven Cemete		2/24/2	011	Hagerstown	n MD
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual he conflict at	ni)	21. Signature of Funeral Service) L 11	22. Name and Addre					
and de pe	8) CM-1/				1				gerstown,	
		23a, Part 1, Enter the disease, or	r complete ions that c	caused the deat	h. Do n						Approximate Interval Between
		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final			32			· C.	-14		Interval Between Onset and Death
Physiciar /Medica	_	disease or condition resulting in death)	OL .	bable	5 1	MO Card	N	12801	CHAN		
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death certificate be executed eathending physician and for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, ou	tcome of pregna	ancy					23d. Date of de	alivery
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e lav has je 2:	ם	The state of the s	0116260	1010	19	110 alco	10	Seren	autopsy perform	ed? prior to	completion of cause of
n: The licate h r, page									1 ☐ Yes 2	⊟No 1 □ Ye	s 2□No
i ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:			notiont 3 DOA Oth	oar:	e of Death (C			
Phys this	은	1 ☐ Yes ♣ No 27. Manner of Death			ER/Out 28b. Ti	patient 3 DOA	4 L N			nce 6 ☐ Other (Sp	ecify)
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ttenc death ttor:	cat	2 ☐ Accident investing in	not bo	of Indiana At he			Yes 2		Landing (Otto		Down & Charles Marine have
or A ifter (Direction by	Certification:	4 ☐ Homicide determ	nined 28e. Place build	ing, etc. (Specif	ome, tari fy)	m, street, factory, office		281.	City or Town,	eet and Number or F State)	iurai Houte Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifiit completely filled in by the funeral director,		202 02 455-24 455 0 455						- T			
Hosp 24 ho Fune tely f	Medical	(Check only 2 Medical	Examiner: On the b	asis of examina		death occurred at the t lor investigation, in my					
thin 2	Med	one) 29b. Signature and title of certifie		ner stated.		29c. Licens	e number		20	d. Date signed (Mor	oth Day Vearl
₽ ₹ ₽ 8		29b. Signature and title of certifie	VIX			Zec. Eldell	119	AU	20		an, Day, 10an
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5H-3		30. Name and address of person		se of death (Iter	n 23a) (*	Type, Print)	· ·	1		il seem	La mo
		W.C. KWZ	era mo	124	47	remission	amer	HVE	nue	Mayers	14/200 11/10
	tate	31. Date filed (Month, Day, Year)		Registrar's Signa	uure 	1				-	2119
Regis		FEB 25	E ZUTT	Heren	A.	par					
HMH 17 Rev 1	/2001					ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 14 2<u>011</u> MIDDLETON PEARL 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 3913 WINDOM ROAD HYATTSVILLE Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours APRIL 16 1923 1 M 2 X F VIRGINIA Director Yrs. 578-28-0034 87 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE'S N. BRENTWOOD 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20722 USA 3913 WINDOM ROAD death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 27 is ar ed other than "natural", or iter trau atic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 2 X No 72 hours after Maryland 21215-0036 Specify: BLACK If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) . Page 1 and 2 shculd be filed within 72 ment of Health an Montal Hygiene. tant: If item 27 is arred other than Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT POSTAL WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MABLE HURLEY LESTER HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3913 WINDOM ROAD N. BRENTWOOD, MARYLAND 20722 ELDRIDGE MIDDLETON/SON Department of Health Important: If item 27 any injury or other to Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation NATIONAL CEMETERY 2/20/2011 LAUREL, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the diserse, or complication in shock, or heart fold in the internal one cause in each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition HYPERTENSION Medical resulting in death) Due to (or as a consequence of) Examiner HYPOVOLEMIA Sequentially list conditions Examine Due to (or as a sunsequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit FAILURE TO THRIVE Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year the g Unknown g Unknown P.O. ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? Yes 2X No 1 Yes 2 X No Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital, Other: 1 🗌 Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury death. 1 Yes 2 No М Investigation Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 within To the 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year D13026 FEBRUARY 17, 2011

Registrar
DHMH 17 Rev 7/2009

State

STEPHEN M. SEABRON M.D. 1140 VARNUM STREET N.E. #209 WASHINGTON, DC 20017

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Hannah Faith Noblick 0826 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Hagerstown Washington County

9. Birthplace (State or Foreign 24 Hrs. Min. 31 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Hours (Month, Day, Yes Mary Land Director Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland | Washington County 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17626 Gettysburg Way 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married Yes 2X No Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jason Matthew Noblick Kelly Beirne Noblick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason M. Noblick-father 17626 GettysburgWay Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 2-18-2011 4 Donation 5 Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Immediate Cause (Final Onset and Death ongenita Physician/ anomalics disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 5 ☐ Other (specify) Pregnant at time of death signed by the aid be detached for 9 Unknown 16 Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? this certificate 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No မ 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Natural
2 Accident
3 Suicident 27. Manner of Death completed filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 5 Pending work 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 71350 erson who completed cause of death (Item 23a) (Type, Print) Boy kin SH-1 31. Date filed (Month, 32. Degistrar's Signature State 2011

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 16 0242AM Robin Marie Oliver Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DITAL thmore timore Baltimore City Social Security Number Birthplace (State or Foreign Country) **Funeral** . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🕱 F 1070471952 DC **Director** 213-66-3134 58 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hyglene. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No MD Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12403 Kembridge Drive 20715 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Administrator Nursing Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel G. Oliver, Jr. Barbara Bowles 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 shou ment of Health and tant: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17405 Holstein Pl., Hughesville, MD 20637 Samuel Oliver, III/Brother permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Buria! 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)

21. Signature of Learn S. Nigro Lee Crematory 02/21/2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ections to light hup Examiner 2 moSequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: မ 1 🖊 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manger of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation Could not be 24 hours after deat Funeral Director; Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Practioner: To the h **Geidlifying Nurse** S1656 who completed cause of death (Item 23a) (Type, Print) trend 31. Date filed (Month, Day, Year) 32. Registra Signature State Registrar

11-01509

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ann Pope	State of Maryland / Department of Health and M 1- For State Registrar Certificate of Death	lental Hygiene 2011 07042
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year February 23, 2011 3. Time of Death 1547 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca Johns Hopkins Hospital Baltimore	
Funeral Director	Months Days H	Under 24Hrs. 8. Date of Birth(MM//DD/YYYY) 9. Birthplace (State or Foreign
	212-64-5580 1 M 2 F 74 Yrs.	March 3,1936 Country) England
O A BIN	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f sh tiffied at once Director	DC Washington DC 10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
h the M	3916 Jenifer St., N.W. 20015	United States
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	kican, Puerto Rican, etc.) White, etc.
urs afte tural",	3 Widowed 4 Divorced in the converteur of Dates:	Give kind of work done 16b. Kind of Business/Industry
5-0036 ed within 72 hour bygiene. other than "natu the Medical Exau Completed	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)	
5-00, ed withi lygiene, other ti	2 Calligrapher/Pa. 17. Father's Name (First, Middle, Last) 18.Mc	Inter Art Other's Name (First, Middle, Maiden Surname)
1121; Id be fil fental F narked event, 1	Leonard Potter	Barbara Giles Number or Rural Route Number, City or Town, State, Zip Code)
MD 21215-0036 at 2 should be filed within 7 ath and Mental Hygiene. m 27 is marked other than numatic event, the Medica To Be Comple		
Baltimore, pensit Pages I and Department of Heal Important: If iter injury or other tra	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition (Name of cemeter) crematory or other place)	
3alti ermit. Departm mports njury o	21. Signature of Funeral Service Licenses 22. Name and Address of Fa	g 3-1-2011 Falls Church, VA
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Complications of Metastatic Carbue to (or as a consequence of):	rcinoid Tumor
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
executed an and al-transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	*
be be	□ AMENDED 23a,27 per me g914 4-6-	ll vt
Division of Vital Records, P.O. Box 6876i no the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tedical Certification: To Be Completed by Physician/M.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ec 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	23d. Date of delivery topic pregnancy Month Day Year
P.O. It res that the signed by the be detached by Ph		n Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by P		24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No
tal Recition: The certificate rector, page	25. Was case referred to medical 26. Place of De	eath (Check only one)
n of Viding Physical After this funeral dir	1 Ves 2 No Post of Levine 2 ER/Outpatient 3 DOA	,
tendin death. stor: A y the fun	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2	No Property of the Property of
Division o Hospital or Attending 24 hours after death. Funeral Director: After filled in by the funeral Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building (Specify)	g, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the How within 24 h To the Fun completely		
W S T S T S	29b. Signature and title of certifier 29c. License num O.C.M.E.	ber 29d. Date signed (Month, Day, Year) February 24, 2011
	30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Str.	eet Baltimore MD 21223
State	31. Date filed (Month, Day, Year) 22. Registrar's Signature	COL, DAMINOTE, WID 21220
Registrar	MAR I WIT About to	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** :02PM FRANCIS SIDNEY PUSEY February 20 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Manokin Manor Anne If Under 24 H Hincess omersi 8. Date of Birth 06-14-1931; Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1√ M 2□ F Months Hours 214-32-1010 76 MD. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show other traumatic event, the Medical Evantian Count be notified at 1 □ Yes 2 □ No Director MD. Somerset Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21853 United States 11977 Edgehill Terrace 23a Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No Specify: Specify: ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Hygiene. Food Service Restaurant Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Romey Pusey Leila Peacock ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Anna Sparks——Sister permit. Pages 1 and 2 and Department of Health an Important: If item 27 is any injury or other trau 5011 Bridge Point Drive, Chester, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory 2-22-2011 Date 20a. Method of Disposition 1 ☐ Burial 2 🏝 Cremation 3 ☐ Removal from State Salisbury, MD. 4 ☐ Donation 5 ☐ Other (Specify) Pusci 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINMAN FUNERAL HOME 21853 11673 Somerset Ave., Princess Anne, Md. M00295 Approximate Interval Between Onset and Death t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line diate Cause (Final ase or condition sulting in death) Physician cerebrovascular accedent 5 MONTHS /Medical Due to (or as a consequence of) Examiner 5 YEARS ASWA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation Natural 1 ☐ Yes 2 🗌 No death. 2 Accident neral Director: / 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 21st 2011 DO51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 - S. DIVISION ST STUSBURY MD21804 DK-USHA NATES AN, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar per physician, 2/18/1 Certificate of Death E.T, WCHD #26, 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RICHARD I. PROCTOR ^Day 20 1° 1° 16:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN ATLANTIC GENERAL HOSPITAL . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 X M 2 □ F Days Hours 140nth, Day, 1932 78 WASHINGTON, DC 577-44-4328 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director DELAWARE SUSSEX BETHANY BEACH 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19930 U.S. WALSTON WALK COURT 33270 death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates. 52-56 1 ☐ Yes 2 X No Specify Specify. "natural" Completed 3 Widowed 4 Divorced 2/10/11 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lepartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event to once. Elementary/Seconday (0-12) College (1-4 or 5+) MANAGEMENT TELEPHONE COMPANY DoD. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOROTHY MCCRONE IRVIN M. PROCTOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOB: 1111313 DOROTHY PROCTOR/WIFE P.O. BOX 768, BETHANY BEACH, DE. 19930 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State DECAWARE VETERANS MEMORIAL CEMETERY 5 Other (Specify) 4 Donation 2-14-2011 MILLSBORO, DELAWARE 21. Signature of Funeral Service MEL^NSON FUNERAL SERVICES, LTD 38040 MUDDY NECK RD, OCEAN VIEW, DE. 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (/ as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events. Examine Due to (or as a consequence of): the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death page 2 should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Tyes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Prantismen To the best of my knowledge, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ocean Confewo Green T10+1 Régistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 15 2011 1:44 P M MARGARET V. PROCTOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Min. Months Days Hours MARYLAND Director 577-24-8689 90 Yrs. T920 Usual Residence of Decedent or 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 H Yes 2 □ No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 19 HARRINGTON PLACE 20774 USA er than "natural", or items the M dical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Specify: BLACK 1 Yes 2 No Specify: If Yes Give 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 lith and Mental Hygiene.
7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) 12TH PRINTING GOVERNMENT or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ THOMAS E. DICKENS CHARLOTTE WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is WILLIAM PROCTOR/SON 7205 HASTINGS DRIVE CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ■ Burlal 2 ☐ Cremation 3 ☐ Removal from State 2/24/2011 *Y*NCOLN CEMETERY SUITLAND, MARYLAND 4 Donation 5 Doner (Specify) J.B. JENKINS FUNERAL HOME, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter th Asea 4, ations the shock, or hear failure. List only one cause of r convecations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate terval Betwe Onset and Death Immediate Cause (Final Physician/ ATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami ending physician and use as the burial-transit Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Pregnant at time of death ned by the a 9 Unknown P.O. been signed the should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? page 2 1 ☐ Yes 2X No 2 X No completed filled in by the funeral director, 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No ည 1 Inpatient 2 X ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 the only one) 29c. License number 29b. Signature and t le of certifie 29d. Date signed (Month, 2 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle | Last) 2. Date of Death Physician/ Day Medical February 201 4a Facility Name (if not institution, give street and number) 4b. City, Town. or Location of Death Examiner 4c. County of Death If Under 24 Hrs. 8. Date of Birth **Funeral** 1 Year 9. Birthplace (State or Foreign 1 M 2 F Months Days Min Month, Day, **Director** Usual Residence of Decedent show 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director or 28a-f 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 Hoo 6 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced Year or Dates Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname), ၉ Page 1 and 2 should be 1 19a, Informant's Name/Re attionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route No eredith 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) Survive of Funeral Service License Bramwey MDZKOR 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 XNo Day Year Pregnant at time of death signed by the Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown the Funeral Director: After this certificate has been a pleted filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 2 **X** No Other: ၉ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death

1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature nd title of certifier 29c. License number R135131 February 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pennie Savage, CRNP 9715 Healthway Dr, Berlin, MD 21811

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

amended item number 20B/2-15-2011/wchd/map and item 20C Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Medical Examiner Provisicion Medical Examiner Provisicion Medical Examiner Provisicion Medical Examiner In Decederth Name (First, Micdel, Last) Sandra L. Parsons A. Time of Dawl Model (County of Death County of Death Count	The properties Controlled			For	State of Maryland	/ Depa	irtment of F	lealth and I	Mental Hygie	ene	
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Day Year)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	o the vithin (o the omple	ž		e Practioner: To the best of my ki	nowledge, d				* * * * * * * * * * * * * * * * * * * *	
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			For State of Maryland / Do	epartment of F Certificate of L			2011	07048
	ù l		Registrar 1. Decedent's Name (First, Middle, Last)	Jeruncale or L		2. Date of Dea	Reg. Nov V	3. Time of Death
	Physicia Medic		Frank Ouick			Month Februar	cy II, 20II	
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Dea	
			Doctor's Community Hospital		ham	1		George's
	Funeral Director		5. Social Security Number 250-28-1139 6. Sex 1 Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 5		thplace (State or Foreign buntry) th Carolina
			Usual Residence of Decedent			RDIII J	, 1923 NOI	th Carolina
	yland •f sho ed at	tor	10a. State 10b. County 10c. City, Town of	r Location				10d. Inside City Limits
	e Mar r 28a- notifi	Funeral Director	Maryland Prince George's	105 7:- 0-1-	Glenn I			1 🔀 Yes 2 🗌 No
	ith th	ral		10f. Zip Code	1.60		10g. Citizen of What Co	
	ems (in in	8104 Maplegate Place 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-	United 14. Race - Ame	
ဖွ	fer de , or it amine	þ	1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No	If Yes, specify Cuba 1 ☐ Yes 2 🛂 No		Rican, etc.)	Black, Whit	
8	ours a tural" al Exe	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates.				Specify: At Am	rican erican
5	72 ho n "na Aedio	nple	(Specify only highest grade completed)	ecedent's Usual Occup Rive kind of work done o e. DO NOT use retired)	ation during most of work	king	16b. Kind of Business	Industry
212	within jiene.		Elementary/Seconday (0-12) College (1-4 or 5+)	C1e	rk	į	Gover	nment
D	filed and the distance of the distance of the seent,) Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, 1	Maiden Surname)	
<u>ya</u>	uld be I Ment narke natic	유	Andrew Franklin Britt			arrie Br		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Mailing Address (S <i>treet a</i> 04 Maplegat			City or Town, State, Zi,	p Code) 20769
ore	le 1 an t of He If iten or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of D cemetry.	isposition (Name of crematory or other plac	(e) Febru	Date Lary 19	20c. Location - City or	Town, State
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	- E	Examiner	Compensation and the conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):					
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SIO	r deat ctor:	rtific	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined		Yes 2 □ No	28f. Location (St	treet and Number or Ru	ral Route Number.
DIVISION	ral or safte al Dire al Dire led in t		building, etc. (Specify)			City or Towr		
	To the propriat or Attending Priysician; the law requires that the deam certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, deadors only one) 1 Medical Examiner: On the basis of examination and/or in the basis of examination and or in the basis of examination a	vestigation, in my opinio	on, death occurred a	t the time, date an	nd place, and due to the	cause(s) and manner stated.
- 1	To the company		29b. Signature and title of certifier	29c. License			29d. Date signed (Monti	
	12		1 Weh me	D24	020		February 1	5, 2011
	TH		30. Name and address of person who completed cause of death (Item 23a) (Type Moti L. Koul, M.D. 4467 Old Bran		Suite 203	B Temp1	e Hills, Mo	i. 20748
10 kg	Stat Registra	· ·	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

DHMH 17 Rev 7/2009

Funeral

ö the Medical Examiner must be 23a ò hours after "natural", than other Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked c Department of Health al Important: If item 27 is any injury or other trau

Maryland 21215-0036

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and -transit Physician; The law requires that the death certificate be executed ng physician an as the burial-t Box 68760 use for ed by the a P.O. Records, certificate has page 2 Division of Vital funeral director. this

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Month Feb. Physician/ Wilfredo Romero 12 9:30 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year, 1 🛣 M 2 🗆 F Months Days 3 Hours Min Director 0 9 Feb. Maryland None Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director MD Montgomery Silver Spring 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20902 USA 2816 Munson Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 X Never Married 2 Married White Salvadorean 1 X Yes 2 ☐ No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilfredo Romero Francisca Nelly Franco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2816 Munson Street, Silver Spring, MD 20902 Francisca Nelly Franco/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. 15, 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis Address Cortins Funeral Home Inc. tosepen 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Interval Between Onset and Death 3 days Immediate Cause (Final Physician/ Trisomy 18 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔀 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a, Date of injury (Month, Day, Year) 27. Manner of Death XX Natural 28b. Time of e Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50522 Feb. 12, 2011 hysicia. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Matthew B. Picard, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 7:10 pm Mary T. Romano Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Burtonsville Sanctuary at Holy Cross Nursing Home Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Italy 8 Date of Birth **Funeral** 7. Age (In vrs. last birthday) Months 1 □ M 2 🗓 F Days 0470571912 Mir 074-22-8635 Yrs **Director** Usual Residence of Decedent 28a-f show with the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland 1 ☐ Yes 2 🕅 No Montaomeru Silver Spring 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? Funeral items 23a 2035 Seattle Avenue 20905 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death villed pertinent of Health and Mental Hygiene.
Important If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 Divorced Specify Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Michael DeVito Saveria Piccininni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Kushan - Daughter 2035 Seattle Avenue, Silver Spring, Maryland 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 02/17/2011 4 Donation 5 DO Other (Specify) Entombrent Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Anemane warker 1232 11800 New Hampshire Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): arlow disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) for use as the burial the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 🖵 🇲 critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier DO 069 death (Item 23a) (Type, Print) 30. Name and address of person who complete Year) 31. Date filed (Month. Dav. 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nancy Gail Reichmeider 7:40 am February Medical 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Month, Day, Year) 1 🗆 M 2 🗓 F Months West Virginia **Director** 233-64-3294 70 Usual Residence of Decedent shov 10a. State be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 28a-f Montgomery Maruland Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a must ! 13007 Lutes Drive 20906 U.S.A permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner muss once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Municipal Clerk Montgomery Co. D.O.T. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Gail Alderton Fletcher Nancu Grace Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Scott Reichmeider - Son 551 Saint John Street, Pleasanton, CA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 02/21/2011 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. M01564 Kat 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or compilirations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, it is a sequentially list conditions, it is cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be as the IF FEMALE nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Pregnant at time of death Day Year 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy To the Hospital or Attending Physician: The performed? Yes 2 death? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 2 🕅 No 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) February 11, 2011 D0063343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 M.D., Irina Ruban,

State

Registrar

31. Date filed (Month, Day, Year)

FEB 16 2011

68760

Box (

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, I're Medical Examinations to a count.	7	10a. State	te 10b. County 10c. City, Town or Location 10d. Inside City								10d. Inside City Limits 1 XYes 2 □ No		
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or Attencuter death	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investigation 6	28e. Place of In	jury - At homitc. (Specify)	e, farm, str				28f. Location (S City or Tow	treet and Nu n, State)	mber or R	ural Route Number,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>23:00</u> P™ 05/03/5077 Ramon J. Rhinehart Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Months Hours Director 246-44-7080 <u>06/29/1932</u> Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Hyattsville 14 Yes 2 No 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 5408 15th Pl. 20782 AZU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?
1 X Yes 2 ☐
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. 3 XWidowed 4 ☐ Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ <u>Social Worker</u> DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Rhinehart Anna Mae Heller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Rhinehart / son 8819 Creekway Dr., Clinton, MD 20735 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery: 02/11/2011 Brentwood, MD uneral Service Litten ee 22. Name and Address of Facility Strickland Funeral Services 21. Signatur 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph, sician/ Hemorrhagic Stroke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertensive Emergency Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) the 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Tension pneumothorax, prostate cancer Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hydronephrosis, End-Stage Dementia Bilateral page 2 s autopsy death? **Director:** After this certificate It in by the funeral director, page 1 Yes 2 No Yes 2 X B B Was case referred to medical 26. Place of Death (Check only one) examiner? 은 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours a Funeral D eted filled i Medical eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) RSM. MD D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar/Ameno#8. PerFHRC3-1-11cr Certificate of Death 2. Date of Death 02 Month Physician/ 14 Day 20^{Year} A M Charles Winston Robinson 6:03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 1**X** M 2 □ F Days Hours Min. Director [955 578-76-9137 55 Usual Residence of Decedent or 28a-f show notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 ី Yes 2 🗌 No DC Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 1006 Kenyon Street NW 20010 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced **Black** the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chauffeur Private Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Patrick Robinson Ruby Mae Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inez P. Robinson / Wife 1006 Kenyon Street NW Washington, DC 20010 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 02/23/2011 Brentwood, DC 21. Signature of Furleral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Enter the disease, or complications trian caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Myocardial infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit Diabetes Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1X Yes 2 No 3 Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform rmed? 2 🎑 No certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this eral Director; After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗓 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ___ Megical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check due to the cause(s) and manner stated only one est of my knowledge, death occurred at the time, date and place, and due to the cause(s) r as stated Signature and title 29c. License number onth. Day. Year 54206 erson who completed cause of death (Item 23a) (Type, Print) Cesar Torres 700 2nd Street NE Washington, DC 20002 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#25 per MB ttk 2/22/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _Month Day Physician/ 640 M 0 20 2011 Medical 4a. Facility Name (if not institution, give street and number Town, or Location of Death 4c. County of Detath 4b. City Examiner Washington m 271 04 -0326x} DOMO ar If Under 1 Year | If Under 24 Hrs. 9. Pirthplace (State or Foreign Social Security Number 8 Date of Birth 6 Sex 7. Age (In yrs. last birthday **Funeral** Days Hours July 10 Year 1957 1 🗆 M 2 🔀 F North Carolina Yrs 53 Director 214-66-8421 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Txt Yes 2 No Landover Hills Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral United States 20784 B-33963 Warner Avenue hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married ð 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than "r
r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ൧ Norman Giddings, Jr. Frances Richardson permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20706 9729 Good Luck Road # 10 Lanham, Maryland Kimberly Davis - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Feb 19,201 Landover Harmony Cemetery Donation 5 Other (Specify) ure of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road NE Washington, DC 20019 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or deart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner TAMONA DIAC Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury GRAFT INJUR To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit BLEEDING FROM that initiated events Due to (or as a consequence of): Qr resulting in death) Last 0 Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DEPENDANCE STEROID 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed DISTASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed? Yes 2 \(\sum \) No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred
WHILE REMOVAL
PACING WIRES 28b. Time of 28c. Injury at Certificate: injury Natural 5 \square Pending work? 2 Accident Investigation 700 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7,00 CATEROLL AVE 6 Could not be 28e. Place of Injury - At home, farm, street, far building, etc. (Specify) HOSPITAL farm, street, factory, office determined 92011 TAKOMA PARK MO 20912 WASHINGTON MOVENIST Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifler 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my moveledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 completed cause of death (Item 23a) (Type, Print) MRHANPAL Glen Dale, Md. 20770 12200 Annapolis Road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg State of Maryland / Department of Health and Mental Hygiene

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Medical Exam	ner	DANEKKA 4a. Facility Name (if not insti		ONA		INSON	4b. City, Tow	or Locatio	on of Death	February	12, 201	1 County of De	0240	nrs
3		Prince George's He			ei <i>)</i>		Cheverly		NI OI DOGGI			nce Geo		
Funeral		5. Social Security Number	6. Sex	7. /	Age (In yrs.	last birthday)	If Under 1		nder 24Hrs.	8. Date of B	irth (MM/DD)/YYYY) 9.	Birthplace (Sta	ate or
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212 212 ould be Ments mark	일	19a. Informant's Name/Relati				19b. Mailin	g Address (S					or Town, St	tate, Zip Code))
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera in Paternal of Health and Mental Hygiera in Insperiment of Item 71 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		LAVERNE P. S	PRIGG	S/MOTHER			DAWN		TEMPL					
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Balt permit Depart Impor injury		21. Signature of Funeral Sen	ijee Licens 3	ee			Name and Add						RAL HOM YLAND 2	
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Box 6876 death certificate the attending phy ed for use as the	iciar	past 12 months?			at time of de	anth -	ther (Specify)	5	pro program		""	01101	July	
BO he deat to the deat to the deat for	Physici	1 Yes 2 No 9		9 Unknown			and advise and		Deti	l 220 Did i	tobacca use	e contribute	to the cause	of death?
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To		30. Name and address of per	son who	multiple cause of	f death (Iten	n 23a)				_	1. 35,4			
7,		Margarita Korell MI		sistant Medica	al Examir	ner 900 W	/. Baltimore	e Street,	Baltimore	e, MD 212	23			
S	ate	31. Date filed (Month, Day, Ye	ar)	32. Regist	trar's Signat	yre /								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:00 PM HOWARD FRANKLIN RICHARDSON 2011 <u>Fe</u>b 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Pines Talbot Genesis HealthCare -Easton 8. Date of Birth (Month, Day, Ye) 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** . 1902 Hours Months Days Min. 217-10-2056 M 2□ F 108 Md. Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be 1 withled at Md. TALBOT EASTON 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 DUTCHWANS LANE 21601 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Howard Richardson Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify: Specify: WHITE 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 WATERWAN SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM RICHARDSON LILLIE MOQUAY ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD S. RICHARDSON / SON P.O. BOX 485 ST. MICHAELS, Md. 21663 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva 2-16-2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State DELMAR, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HURLEY & OSTROWSKI FUNERAL HOME P.A. p.o. Box 518 St. Michaels, Md. 21663 Joseph M. C.f.SP Ostrawski 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause an each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Peath Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) Records, P.O. 9 Unknown signed by to significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 eutopsy perfort certificate Division of Vital 1 ☐Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No director Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 🗆 Yes 2 🗌 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei (Check only one)

State Registrar 29b. Signature and title of certi-

HCHAE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

GIO DUT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Z Physician/ 504-M Betty J. Rogers Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death feninsula nlista DICOMICO Regional medical 8. Date of Birth (Month, Day, Jan. 8 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F Country)
Marvland Director 218-24-5087 81 Jan. Usual Residence of Decedent artment of Health and Mental Hygiene.

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injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Wicomico Sharptown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Church Street 21861 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married Completed by 2 X No Yes 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: white Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) flower shop florist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gordy Bennett Fannie Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Warren A. Rogers (husband) 203 Church Street Sharptown, MD 21861 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Firemen's Cemetery 02-14-2011 Sharptown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Short Funeral Home 23a. Part 1. En y r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Delmar, DE Interval Between Onset and Death Immediate Cause (Final Physician/ Chrenic. disease or condition resulting in death) Medical Examiner UNOSCIENO A Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page performed? Yes 2 No Hospital or Attending Physician: The 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 **N**No ည 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 2 Accident 5 Pending work? 1 ☐ Yes neral Director: Aff 2 🗌 No Investigation 3 Suicide
4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Pwithin 2 only one and title of certifier 29b. Signature D 36014 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21804 UNITORD ST SOYIS SALISBULY MD we nov1 106

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 20TT 6:55 Αм William Oren Ritter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs. Funeral Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 01-17-1925 1 🕅 M 2 🗆 F Hours Min. Tennessee Director 410-24-8800 86 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 664 West Bay Front Road 20711 USA 12. Was Decedent Ever in U.S, Armed Forces? 1 \(\overline{A} \) Yes 2 \(\overline{D} \) No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. and 2 should be filed within 72 hours after d Health and Mental Hygiene. tem 27 is marked other than "natural", or i ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates. 1943-46 white traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) lobbvist military, defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sebastian Nona Lucille Marles Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Department of Health Important: If item 27 any injury or other to 27180 Baptist Church Rd., Mechanicsville, MD 20659 William E. Ritter, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 02-15-11 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee Harmony Lane, Owings, Mt. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. and Deat Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f 2 No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) examiner? 2 No Hospital: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide injury work? 5 Pending after death. Director: Aft 2 🗌 No Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature License number cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

11-00752 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeffrey Scott Ritchey State of Maryland / Department of Health and Mental Hygiene 1- For State Amend#5,17,19a,19b,20a, Certificate of Death me2/18/2011ccdohrbes No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ **Medical Examiner** Jeffrey Scott Ritchey 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 6005 McKay Drive Brandvwine 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months 55 577 84 0129 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 20613 6005 McKay Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Yes 5 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene.

ant: If item 27 is marked other than ", or nther traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 auto mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter L. Ritchie Ritchey æ 19a. Informant's Name/Relationship (Type, Print) မ Stephen Steven Ritchey - brother 20a. Method of Disposition

Mary Geiger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
700 Champions Dr Apt 701; Lufkin, Texas 75901 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State

Month Day January 27, 2011

Feb 18, 1955

Min.

4c. County of Death

10g. Citizen of What Country?

Specify: White

auto industry

16b. Kind of Business/Industry

14. Race - American Indian, Black,

USA

Prince George's

1040 hrs

Foreign Germany

10d. Inside City Limits 1 Yes 2X No

Death

Year

2 No

crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Donation 5 Stother Spe Lee Crematory Feb 15, 2011 Clinton, MD 21. Signature of Funeral Service Licensee Ronald S. W Wade, Director

Diabetic Ketoacidosis

per dvr 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility State Anatomy Board Lee Funeral Home 6633101d Alexandria Ferry, RdD Clipton, MD Approximate Interval een Onset and

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated

X UNPENDED

events resulting in death) Last

Physician

/Medical

≛xaminer

and

Hospital or Attending Physician: The law requires that the death certificate be

this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

After the

Division of Vital Records, P.O.

Box 68760,

Examiner

Physician/Medical

δ

Completed

Be

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Certification:

Medical (Ch

298

25. Was ca

examine

. Hon inide

29b. Signature and title of certifier

Due to (or as a consequence of) Due to (or as a consequence of):

Due to (or as a consequence of):

AMENDED 21 per ab, 23a, 27 per me g913 3-10-11 vt

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown

25	20c. If yes, outcome of pregnancy							
1 [Live birth	2						
4[Pregnant at time of death	5						
ا م ا	Linkson							

-				•
	Fetal death	3	Ectopic pregnancy	
7	Other (Specify)			

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? No 2

art II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Pa

Was an
autopsy
performed?

)	3 Probabl	y 4 ✔ Unknown
24	prior to comp	sy findings available pletion of cause of
	death?	

Scene

				1 ✓ Yes 2 No	1 🗸 Ye
se referred to medical		26.Plac	ce of Death (Check	only one)	
er? 'es 2 No	Hospital 1 Inpatient	2 ER/Outpatient 3 DOA	Other Nursi	ng Home 5 Residence	e 6 🗸 Other
of Death	28a Date of Injury	20h Timo of Injury 20a Jul		COL Describe here for a	

Manner of Deat	h	28a. Date of Injury	28b. Time
1 X Natural	5 Pending	(Month, Day,Year)	
2 Accident	Investiga		
3 Suicide	6 Could no		home, farm, s
Manufetta .	determin	ed (Specify)	

	1 Yes 2 No	
treet, factor	y, office building, etc.	

900 W. Baltimore Street, Baltimore, MD 21223

28f. Location (Street and Number or Rural Route Number, City or Town, State)

a. Certifier	1	Certifying Physician:	To the best of my knowledge, death occu
)	2	Medical Examiner: On	the basis of examination and/or investiga

and manner stated

leath occurred at the time, date and place, and due to the cause	e(s) and manner as stated.							
r investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
29c. License number	29d. Date signed (Month, Day, Year)							

Punula Fredhell, MI)
30. Name and a dress of person who completed cause of death (Item 23a)

O.C.M.E.

January 28, 2011

Pamela E. Southall, MD Assistant Medical Examiner

FEB 1 8 201

32. Registrar's Signature

DHMH 17 Rev 1/2001

OCME 2006

11-00753 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#12perfuneralnome2/16/2011ccdohrb Mary Ritchey 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 27, 2011 **Medical Examiner** 1043 hrs Mary Ritchey 4a. Fecility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6005 McKay Drive Prince George's Brandvwine If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Davs Hours Director May 12, 1927 country)Idaho 518-26-6967 1 M 2 XF 83 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 X No MD Prince Georges Brandywine Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6005 McKay Drive 20613 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces?
Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural",
injury or other traumatic event, the Medical Examiner. 3 Widowed Yes, Give Year 1 Yes 2 X No specify: Specify: white 4 X Divorced 1948-1949 δ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Education and doctor's office 12 exectuive assistant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Bertha May Coates Be Thomas C. Cei 19a. Informant's Name/Relationship (Type, Print) ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3980 Champions Rd Apt 701; Lufkin, Texas 75901 Stephen Ritchey - son 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State Date crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Epecify: in state Lee Crematory <u>Feb 15. 2011</u> Clinton MD 22 Name and Address of Facility Astertand 112 Terry Rd, Legi Fungral 21. Signature of Funeral Service Licensee Ronald S. Wade, Director per dvr 55 W. Baltimore St; Baltimoré, MD 21201 20735 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease Complicated ediate Cause (Final disease a. by Hypothermia Between Onset and /Medical Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Sal me yt g913 3-10-11 vt 23a,pt.II,27 21 per ab g X UNPENDED AMENDED Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 ✔ Unknown Dementia Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 X No fd 1-27-11 fd 10:43am 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Certific 3 Could not be Suicide or Town, State) 6005 McKay Drive randywine, Md. determined (Specify) residence Homicide Brandywine, 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 28, 2011 Y amel G reuthall, MP 30. Name and address of person who completed cause of death (Item 23a) 185 Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32 Registrar's Signature 31. Date filed (Month, Day, Year) State and

DHMH 17 Rev 1/2001 OCMF 2006

Registrar

FFR 1 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:55P M 17, 2011 February Alonzo Resley Warren /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Williamsport Peachtree Lane If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2□ F 08/15/1928 Maryland 82 Director 218-24-2162 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any ilury or other traumatic pure any ilury or other traumatic pure. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1X Yes 2 □ No Director Williamsport Maryland | Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21795 1 Peachtree Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify. Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tire Retail Owner Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeannette Floyd Conrad Resley Alta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alan Resley / Son 4206 Cole Pond Dr. Durham, North Carolina 27705 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery | 02/21/2011 | Hagerstown Maryland 21. Sign turn of Funeral Service Lic-22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) signed by the a d be detached for 1 Tyes 2 No Ö 9 Unknown ₫. contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 254 No 3 Probably 4 Unknown 1 🗌 Yes has been sie 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 nis certificate I 1 □Yes or Attending Physician: 26. Place of Death (Check only one, Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) **DNO** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 □ Yes this Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral of 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Division Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. ieral Director; / filled in by the fi Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 16605 Kendle Pd. cause of death (Item and address of person with

State

2H 5+1

31. Date filed (Month Registrar

phannor

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patrick Francis Rucker 6:26 February 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18923 Geeting Road Keedysville Washington Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F March 16. Months Days Hours Min. 213-56-9412 **Director** 59 Washington, DC Usual Residence of Decedent 28a-f show Hygiene. other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18923 Geeting Road 21756 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Cement Layer should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Thomas Joseph Rucker, Sr. Emily Anne Huston and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Rucker / sister-in-law 12317 Rambling Lane, Bowie, MD 20710 injury or other item 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot remetery, crematory or other place)
Maryland National
Memorial Park 1 Burial 2 Cremation 3 Removal from State 2/19/2011 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue RAYROSEN Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for se a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events physician and the burial-transit Exam that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 1 L Yes 2 L 9 L Unknown 9 Unknown P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an his certificate has b I director, page 2 sh autopsy prior to completion of cause of death?

1 Yes 2 No Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Mactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one 29b. Signat and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2570000

State Registrar 31. Date filed (Month, Day, Year)

September 18 2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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9 Saist Paul Street,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#11 per FH 02/25/2011 Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 2 th 15 - 2011 2125 P M Harold John Roberts, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Ctr. Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 09-25-19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 😿 M 2 🗆 F Days Hours Min. Director 579-64-4546 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Director 1 TyrYes 2 No MDPrince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ "natural", or items 23a o Funeral 1164 Booker Drive USA 20743 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12th College (1-4 or 5+) Sewer Service Foreman DC WASA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Dorothy Montgomery Harold John Roberts 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) III 1164 Booker Dr.,Capitol Heights, MD 20743 Harold John Roberts, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Natl. 02 - 26 - 201Landover, MD Harmony 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland,MD L. Tisher MO1616 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 days Immediate Cause (Final Physician/ Gram Negative Sepsis Medical resulting in death) Due to (or as a consequence of): Examiner 3 days Gram Negative Pneumonia Sequentially list conditions, if any, leading to increasing cause. Enter Underlying Examine Due to for as a consequence of: 2 months Cause (Disease or iinjury Respiratory Failure Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Lung Cancer 1 Yes 2 No 3 Probably 4 Unknown page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Lung Disease 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ၉ 1 Yes 2 V No 1 ▼ Inpatient 2 □ ER/Outpatient 3 □ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Sympleted filled in by the fun Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of pry knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D16273 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6130 Landover Road, Cheverly, MD20785 Revathy Murphy,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death KOBINSON Year **Physician** JANUARY 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner** HOSPITAL PRINCE PRINCE GEORGE'S GETRGE'S CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Year! 1□ M 2XF Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Completed by Funeral Director GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20746 Items 23a U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 than "natural", or 1 ☐Yes 2XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) INFANT INFANT permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any Injury or other traumatic event, the once. 0 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD, ROBINSON-MOTHER SUITLAND, CHANDA ELENA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 02/12/2011 CHEVERLY, MD PRINCE 4 □ Donation 5 □ Other (Specify) GEORGES HOSP HOSPITAL DRIVE 3001 22. Name and Address of Facility 21. Signature of Funeral Service Licensee PRINCE GEORGES CENTER HOSP CHEVERLY, MD 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** as a consequence of) /Medical Examiner Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part | Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Drat 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 2 □ Accident (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier (a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number and address of person who complete (Type, Print)

Kith

State Registrar 31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Maryland		tificate of D			eg. N2 0 1 1	07066		
ľ	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	th Day Year	3. Time of Death		
	Medic Examin	al	Fran 4a. Facility Name (if not institution, give str	ncis Adolph	Spea	4b. City, Town, or	Location of Death	Februar	21, 2011 4c. County of Deat	1 2:33		
	Examin		Southern Marvland	Hospital Cent	er		Clinton_		Prince George's			
I	Funeral Director		5. Social Security Number 220-16-9024 6. Sex	7. Age (In yrs. la	st birthday) 84 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	Year) Co	thplace (State or Foreign untry) Maryland		
		Ļ	Usual Residence of Decedent 10a, State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits		
	larylan 3a-f sh iffied a	Funeral Director	Maryland St. Mai		, , , , , , , , , , , , , , , , , , , ,		ollywood			1 ☐ Yes 2 🐼 No		
	a or 28	ΩÏ	10e. Street and Number	Ly 5		10f. Zip Code	7		10g. Citizen of What Co	ountry?		
	th with ms 23 must	nera	24941 Sotte	er1ey Road 2. Was Decedent Ever in U.S	12 \	Mas Decedent of His	20636	cify Yes or No-	14. Race - Ame	SA erican Indian		
٥	er dea or ite miner	by Fu	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Forces? 1 X Yes 2 □ No		Vas Decedent of His f Yes, specify Cubar		Rican, etc.)	Black, Whit			
200	rurs aff tural", al Exa		3 Widowed 4 Divorced 15. Decedent's Educ	If Yes, Give Year or Dates.		lent's Usual Occupa			Specify: B1 16b. Kind of Business	ack		
ر د	an "na Medic	Completed	(Specify only highest grade	cation e completed) College (1-4 or 5+)	(Give I	kind of work done di O NOT use retired)	uring most of worki	ng	United	States		
7.7	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 25a or 28a-f show martic event, the Medical Examiner must be notified at	Be Co	8			Truck	Driver 18. Mother's Name	- (Final Mindella I	Gover	nment		
and	be filer lental H rked of ic ever	일	17. Father's Name (First, Middle, Last) .Toseph A	lexander Spea	ars		16. Mother's Name		larie Fenwi	ck		
Maryland 21215-0036	age 1 and 2 should be ont of Health and Ment it. If item 27 is marked y or other traumatic e		19a. Informant's Name/Relationship (Type			ng Address (Street a	and Number or Rura		oute Number, City or Town, State, Zip Code)			
	and 2 s Health em 27 ther tra		Regenia Frederick S 20a. Method of Disposition			24941 Sot		oad, Ho	11ywood, MI 20c. Location - City or			
nor	Page 1 nent of I ant: If its ury or or		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State C	emetery, cren	natory or other place s Cemete	e) Mar	ch 1, 011	-	, Maryland		
Baltimore,	permit. Page Department of Important: II any injury or once.		21. Signature of Funeral Service Licensee	7	22	2. Name and Addres	s of Facility Matt	tingley-Ga	ardiner Funer Leonardtown	al Home, P.A.		
П	20 E E O		23a. Part 1. Exter the disease, or complic	cations that caused the death	h. Do not ente	er the mode of dying				Approximate		
- 1	Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.		ria with	1			Interval Between Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a consequ			-					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	Jehice Jij.							
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C. Due to (or as a consequence of):								
_	icate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a consequ	uence of):							
3760	ficate t g phys	Medical	d									
89 ×	th certi	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23d. Date of de Month	elivery Day Year							
Box	he dea y the a ched fe	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of c	death 5 L	Other (specify)						
P.0	s that t gned b be deta		Part II. Other significant conditions con Acuft Wyo (www.	1 //	sulting in the u	underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?		
rds	require been si should	eted	Galdtan Read	Disease on	Hen	no de she	A 1 'a	24a. Was		utopsy findings available		
Records,	he law te has age 2 s	Completed by	machinge 10000	013 600 12 10	, .,	7	(10)	autop perfo 1 Yes	rmod2 death?	prior to completion of cause of death? 1 Yes 2 No		
tal	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	ospital:		26. Pla	ace of Death (Chec	k only one)				
of S	Physi r this c eral dire	e: 10	1 Yes 2 No	1 Inpatient 2 28a. Date of injury	28b. Time o	nt 3 L DOA f 28c. Injury	4 ∐ Nursing Hoy y at		lence 6 Other (Spe ow injury occurred	ecify)		
ono	ending eath. or: Afte he fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury		Yes 2 No					
Division of Vital	l or Att after d Direct		4 Homicide determined	3 Usucide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f.								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examine	cian: To the best of my know er: On the basis of examinatio	n and/or inves	stigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due to the	e cause(s) and manner stated.		
	o the Hithin 24 o the Formplet	₩	only one) 3 Certifying Nyrse 29b. Signature and title of Certifying	Practioner: To the best of m	y knowledge,	death occurred at the	e time, date and plac	ce, and due to the	e cause(s) and manner a 29d. Date signed (Mon	is stated.		
	FSFÖ		> Krom	- m	D	Doc	55120		Feb 22nd	2011		
2	-		30. Name and address of person who co Richard PALMER M	mpleted cause of death (Item AD 1328 South			in the 210	hanhin	stombe 20	(03)		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	/	The state of the s	ANTITOTION OF THE PARTY OF THE	Julian	. 34		
	Registr	ar	FEB 2 4 2	011 Seneur	pl. st	parks.						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February JOHN K. SIMMS 124, 2011 1:20 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3105 Gold Mine Road Brookeville Montgomery Social Security Number 8. Date of Birth May 26 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Days Months Hours 217-34-1213 73 T937 Washington, D.C. Director Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Brookeville 1 Yes 2 No ō 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 3105 Gold Mine Road 20833 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify. White 3 Widowed 4 Divorced Completed 2 should be filed within 72 hours of the and Mental Hygiene.
27 is marked other than "natural traumatic event, the Medical E. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Property Management Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jack Bond Simms Janet Elizabeth Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Pamela R. Simms / Wife 3105 Gold Mine Road, Brookeville, Md. 20833 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2/15/2011 Alexandria, Virginia 21. Signature of Fundal Saruce Lannsee ²² Name and Address of Eacility.
Muriel H. Barber Funeral Home
P. O. Box <u>5038</u>, <u>Laytonsville</u> 20882 23a. Pary 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, Heart Failure Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Due to (or as a consequence of) and -transit Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury COPD that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death signed by the a 2 🗆 No 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy perform certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 🔀 Residence 6 Nother (Specify) 2 X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛮 Natural 5 Pending injury 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. ☐ Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kahu

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625, ROCKVILLE, MO

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strar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month Physician/ Dotson Swiney 4:00 A^M 05/08/5077 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Home Prince Georges <u>Hyattsville</u> 1 Year If Under 24 Hrs Days Hours Min. 9. Birthplace (State or Foreign Country) AR Social Security Numbe 8. Date of Birth 7. Age (In yrs. last birthday **Funeral** Months (Month, Day, Year) AR 1 XM 2 🗆 F 96 429-09-3108 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 XYes 2 No Washington DC 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 50035 AZU 9th St. death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Black Specify: "natural" Completed 3 X Widowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Maintenance 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Swiney Henrietta Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8622 Kittama Dr., Clinton, MD 20735 Amando Bowman / nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 05\7P\5077 Suitland, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign kure o Funeral Service) 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 Approximate
Interval Between
Onset and Death
UNKNOWN caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part T. Enter the disease, or complications that shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury Due to (or as a consequence of) ysician and e bunal-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death 5 Other (specify) Yes 2 No 4 Pregnant
9 Unknown 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to dical examiner? 26. Place of Death (Check only one) Be Hospital: 2 No ဂ္ဂ 1 Tes oursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of certifier

Registrar

State

32. Registrar's Signature

15216 DINO DRIVE, BURTONSVILLE, MD 20866

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHOW DHURY,

31. Date filed (Month, Day, Year,

7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Manderin Hospice House Harwood g. Birthplace (State or Foreign Country) Md. Fairmont Hgts, Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Days Hours 1 M 2 M Director June 578-30-1413 83 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 2a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland Prince Georges Oxon Hill 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20745 United States 2000 Norlinda Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify: 3 Widowed 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Housewife 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Duddley Elsie Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2000 Norlinda Ct. Oxon Hill, Md. 20745 John Scott / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (5 Date Important: If any injury or Maryland Veterans 3/7/2011 Cheltenham, Md. Donation 5 Other (Specify) 22. Name and Address of Facility Alexander S. Pope. /P 5538 Mariboro Pike/ 21. Signature of Funeral Service Licensee Förestville, Md. 20747 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Betweer Onset and Beath Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): dramy, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) signed by the a 2 No Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Donknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 Nursing Home 5 Residence 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred touse Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 31 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person HTFOOT-TAYLOR LLS DEFENSEHWY ANDAR NEVIEUE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racks Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 3:34AM Feb 2011 OMA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Genesis Healthcare-The Pines Easton 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min Yrs. Mary land Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f shov Examiner must be notified at 1 Yes 2 No on Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1 6 utchmans items 23a Funeral death 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 ☐ Yes 2 ₺No Baltimore, Maryland 21215-0036 0 Completed by 3 Widowed 4 □ Divorced "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Dipoctant: If them 27 is marked other than "natur any injury or other traumatic event, the World and Industrial and Industrial Expensive States of the States of 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Farm -arm-Hand 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cordova 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State aston, Maryland Chapel 26 Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Henry Funeral ITU Sh Cambri 510 washington Sh Cambri ae.MD. 21613 Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each ine. Do not enter the mode of dying, such as cardiac or respiratory arrest, death. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical your Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ears The law requires that the death certificate be executed and burial-P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 □ No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day 9 Unknown Part II. Other significant conditions contributing to death but no resulting in the underlying cause given in Part I.

Therefore Melithus, Death of the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No certificate 1 □Yes 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica director, 26. Place of Death (Check only ne) 25. Was case referred to medical examiner? Be Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To completely filled in by the funeral 27. Mapher of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □No 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who compl ed cause of death (Item 23a) (Type, Year) State

DHMH 17 Rev 1/2001

Registrar

Savoy

Thomas

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb"14, 2011 Marie Ruth Saunders 0220 M 0000 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Gaithersburg Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 3 Days 577 46 1305 1 □ M 2 □**y**F Hours July 16, 1935 75 Washington DC Director Usual Residence of Decedent 100 10a. State death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XX No Maryland Montgomery Rockville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or items 23a Funeral 9701 Veirs Drive United States 20850 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. 21215-0036 1 Yes 2 No Specify 3XX Widowed 4 ☐ Divorced Specify. White mari the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Government Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Everett Goihew Marie Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul M. Saunders (son) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 1096 Plum Tree Run Drive, West Minister, MD 21157 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Lee Crematory 2/17/2011 Clinton, MD 21. Sign Jure of Funeral Service Licensee 22. Name and Address of Facilities Funeral Home, Inc 6633 Old Alexandria mo1222 Ferry Road, Clinton, MD 20735 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ 560515

Due to (or as a consequence of): Medical resulting in death) Examiner gastrointestina Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dura (or as a consequence of): Exami To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit myocard Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month 1 ☐ Yes ∠ € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hospital or Attending Physician: The 124 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge deet occurred at the time, date and place, and due to the cause(s) and manner stated date and place, and due to the cause(e) and mainter as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical CXT Dr Rockville Sherri Deborat 9901 31. Date filed (Month, Day, Year) FEB 18 2011 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. Pay 16 James Elis Shubrooks 2011 4:55 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice of St. Mary's Callaway St. Mary' S Social Security Number 8. Date of Birth Month Day, May 29 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 XM 2 □ F Months Days Hours , 1935 Director 218 30 8247 75 May Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Park Hall St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral r than "natural", or items 23 the Medical Examiner must USA 47810 Park Hall Road 20667 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 3 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental File of Health and Mental Fitem 27 is marked or Samual Shubrooks Juliet Milburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47810~Park~Hall~Rd.Park~Hall,MD~20667Mary Shubrooks/ Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 2/26/2011 Leonardtown, MD Charles Mem. Garden 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Briscoe-Tonic Funeral Home | 2294 Old Washington Rd. Waldorf Md 20601 Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death ALZHEMES Immediate Cause (Final Physician/ ADVANCED disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a suresquence of): and I-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant Pregnant at time of death 5 Other (specify) 1 Yes 2 g Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2-No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director, After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) hospice Hospital 2 🗔 No 1 Yes ျပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 56076

12B4

State Registrar

DHMH 17 Rev 7/2009

MD

Barker

GILL

32. Registrar's Signature

SMAM ASSOCIATES, LEONALATONA MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJBINDER

FEB 18

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 1:52 PM Peter Sibley 111 Rebruary Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 3421 DODGE PARK ROAD #204 HYATTSVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗓 M 2 🗆 F Months Hours $m JUNE ^{(Month, Day)}$ FLORDIA 1959 Director 267-33-0549 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 K Yes 2 □ No HYATTSVILLE MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 USA 3421 DODGE PARK ROAD #204 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No ARMY Completed by Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE 12TH TOLL_TRUCK DRIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ BLONDIE CHATMAN PETER SIBLEY JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 STAND FAYE DRIVE UPPER MARLBORO, MARYLAND 20785 DEBORAH O'NEIL/SISTER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State PÉVERDALE CREMATORY | 2/18/2011 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signifure of Funeral Service Incensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury signed by the attending physician and deetached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) 1 Yes 2 9 Unknown completed filled in by the funeral director, page 2 should be detached 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ₺ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗖 No 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 🖆 Natural 5 Pending 2 Accident
3 Suicide Investigation 124 hours after deat e Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 MSRYapuhren D DO057465 2/17/1

State Registrar C- ZU3

MD

Baltimore

21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 Smilh AV

N. S. RajapakseMD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> Month Physician/ 2:30 P M Mary Esther Thomas February 18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital 8. Date of Birth (Month, Day, Year) March 31, 1921 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours 89 Mary land Yrs Director 220-14-6493 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 1 ☐ Yes 2 To No Hollywood St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20636 USA 24778 Blackistone Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 😿 No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 x Widowed 4 □ Divorced Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 l h and Mental Hygiene. **7 is marked other than "r** United States Elementary/Seconday (0-12) College (1-4 or 5+) Government Budget Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev. ည Mary Luceria Mattingley George Washington Lafayette Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24778 Blackistone Road Hollywood, Maryland Barbara Jean Emory/ Daughter altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date February 22, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery Hollywood, Maryland 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Onset and Death Immediate Cause (Final Physician/ Dn Cumon19 disease or condition Medical resulting in death) Due to (or as a cons quence of): AD Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Dus to for as a consequence on DM aate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 24a. Was an autopsy performed?

1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 28c. Injury at work?

1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title o 47066 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

181

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3

DHMH 17 Rev 7/2009

Registrar

Avani D. Shah MD

31. Date filed (Month)

FEB 2

32. Registrar's Signature

22650 Cedar Lane Court, P.O. Box 404 Leonardtown, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Month Physician/ 201 NANCY ANN TYLER Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner COMIC ional Madicul Conto Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 03/02/1936 Min. Country) 1 🗆 M 2 屎 F **Director** 217-30-9546 Maryland Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10h County 10c. City, Town or Location within 72 hours after death with the Maryland Director Maryland 1 Yes 2 No Somerset Rhodes Point 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 3438 Smith Island Road 21824 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. ie**m 27 is marked other than**' College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Enos Evans Marie Evans 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lester L. Tyler (Husband) 3438 Smith Island Road-Rhodes Point, MD 21824 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Calvary Church Ceme. 02/24/2011 Rhodes Point, MD 21. Signature Funcial Service 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Robert H. Bradsbaw 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Wegerer Grandonatoris 3 Medical resulting in death) Due to d as a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence or or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo has 1 ☐ Yes 2 ☐ No this certificate 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No death. M Investigation 6 Could not be Accident 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 29c. License number 1 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YOGE'S H VOHRA 910 FA STERN SHORE BE, SALISBULT,

State Registrar 31. Date filed (Month, Day, Year)

FEB 2

DHMH 17 Rev 7/2009

32. Registrar's Signature

3 201

Connie Miles Tov		Please Type end State I- For State	or Print in B of Maryland	/ Depa		of Hea	ith an				_	011	07077
Physicia Medical Examin	ın/	Registrar 1. Decedent's Name (First, Middle,La CONNIE D. TO			incate	OI Dea	ui		2	. Date of De	Reg. No. ath Day 15, 2011	Year	3. Time of Death 1844 hrs
		4a. Facility Name (if not institution, g 27815 Riverside Drive, E		·)			Town, or sbury	Location of			4c. Co Wice	unty of Death omico	
Funeral Director		5. Social Security Number 218-48-6821	Sex 7. A	ge (In yrs. I: 64	ast birthday)	Yrs. If Une	der 1 Yea		Min.	1	irth(MM/DD/ 6-1946	Foreig	thplace (State or gn untry) Md •
tith the Maryland 23s or 28s-f show any notified at once.	Director	Usual Residence of Decedent 10a. State 10b. County Md. Wicom: 10e. Street and Number		Sa	Town or Lo	ry	ip Code	11				of What Cou	
r death w	by Funeral Di		12. Was Deceden Armed Forces 1 Yes 2 d If Yes, Give Year or Dates:	it Ever in U. ? 2 🔀 No	1[If Yes, spec	dent of His	spanic Origi n, Mexican, specify:	Puerto R		0- 14. Spe	Race - Amer White, etc.	ican Indian, Black,
0036 within 72 hours. giene. ner than "natur! Medical Exami	Completed t	15. Decedent's Education (Specify Elementary/Secondary (0-12) 1 1 17. Father's Name (First, Middle, Las	College (1-4 or			dent's Usua g most of wo aning	orking life	Lawn	use retire Care	d) e			Industry Engineer
21215-	To Be C	Ashton Miles 19a. Informant's Name/Relationship			19b. Mai	ling Addres	ss (Stree	Josaj	phine	e Klav	erweid	len Mi.	. Zip Code)
e, MD 1 and 2 show Health and item 27 is retraumatic		Steve Townsend 20a. Method of Disposition	Nephew	20b.	133 Place of Disperentatory or	position (Na	ame of ce			Date	20c. Loca	ation - City or	
Baltimor permit. Pages Department of Important: If		1 Burial 2 Cremation 3 4 Donation 5 Other Specifications of Funeral Service Lice	y: insee	100295	hingt	on Ce	mete d Addres	s of Facility			AN FUN	Yland NERAL	
Physician /Medical	0		recations that cause	d the death	. Do not ente	er the mode	Some	rset A , such as ca	AVE.	, Prin	rest, shock,	Anne,	Approximate Interval Between Onset and Death
* *\d	ē	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a cons			"	_						
cecuted 1 and - transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence o	f):	-							
के हैं ह	Medical	UNPENDED [AMENDED 23c. If yes, outco	me of prea	nancy				_		23d. Da	ate of deliver	у
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Med	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow	1 Live birth 4 Pregnant a		2	Fetal death Other (Sp		Ectopic	pregnan	cy	Moi		Day Year
F. P.O. ires that the signed by a lbe detached	É	Part II. Other significant conditions	contributing to dea	th but not re	esulting in th	ne underlyir	ng cause	given in Par	rt I.				the cause of death? bably 4 Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Completed	25. Was case referred to medical	-				26 Place	e of Death (Check or	1 ✓ Yes			utopsy findings available completion of cause of
Vital I hysician: this certifi	To Be	examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2	ER/Outpati	ent 3	DOA	Other ₄			Residence	6 🗸 Othe	r: Scene
sion of trending Ph death. ctor: After i		27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investiga		Year)	28b. Time		1	Yes 2	No		how injury o		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could no determin 29a. Certifier 4 Coulding Rhyal	ed (Specify)							or Town,	State)		ural Route Number, City
To the Hos within 24 h To the Fun	ledical	(Check only	clan: To the best of r er:On the basis of exa and manner stated	amination a									
	ž	29b. Signature and title of certifier	-			29	9c. Licens O.C.	M.E.				signed (Mo	nth, Day,Year) 11
10		30. Name and address of person who Ana Rubio MD. Assist:	completed cause of ant Medical Exa			altimore	Street,	Baltimo	re, MD	21223	•		
St: Regist	_	31. Date filed (Month, Day, Year) FEB 18 201	32 Registr	ar's Signati	re de	and I							

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ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 1954 M Virginia Fisher Trader eloruan 20 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisburg Wicomica Salisbury Rehabilitation & Nursing Ctr If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Hours Min. 1 4971171 928 Virginia **Director** 82 228-48-1488 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 XYes 2 No MD Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō ems 23a or r must be r Funeral USA 21851 720 Tenth Street items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or itel Armed Forces' Black, White, etc. by 1 Never Married 2 Married Yes 2 XNo 21215-0036 1 Yes 2 No Specify: If Yes. Give White Specify: Completed 3 Widowed 4 Divorced Year or Dates. is marked other than "natu aumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Utilities Operator Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ellen Colbourne Paige D. Fisher, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Holland Rd., New Church, VA 23415 Edward Paige Trader(son) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Oak Hall, Virginia 4 Donation 5 Other (Specify) Downing's Cemetery 2/23/2011 Signature of Funeral Service Licer Holloway Funeral Home, Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on with line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) unes Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Rug a attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death been signed by the sahould be detached it a Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 4No ဂ္ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending Investigation Could not be Accident the Funeral Directory filled in by the Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA I illiam 31. Date filed (Month, Day, Year) FEB 2 32. Pégistrar's Signature State 2 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service	Licensee	1510				ss of Facility W.H.				ome, Inc.
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death certificate has been signed by the attending physici To the 24 meral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical			p Physician: To the bes									stated. e cause(s) and manner stated
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Clara 20 Î V. 1:41 a M Taylor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Prince Georges Hospital Cheverly 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 23, 1946 1 □ M 2 🖾 F Months Days Hours Min. 487-54-6828 Mansfield, La. Director 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1_X Yes 2 □ No Missouri Kansas City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8405 Newton Ave. #3405 64138 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 21215-0036 .1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed **Black** Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 11th College (1-4 or 5+) Certified Nursing Assistant Medical be filed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nob1e Jones Clara Turner permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophia Bloodsoe/ Daughter 5247 Euclid Ave. Kansas City, Mo. 64130 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Forest Hill 2/25/2011 Kansas City, Mo. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service I 22. Name and Address of Facility
Alexander, S. Pope, Profestville, Md.
5538 Mariboro Pikė/Prorestville, Md. Part I feet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final neumoma Priysician/ Blutera disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Ebsiella nehmonia Cequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Nefactatic (ancer Hospital or Attending Physician; The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last signed by the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Cophmonory 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No nechos 24a. Was an autopsy page 2 Cirrhosir of the 1101 certificate 25. Was case referred to medic examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director; A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOU43662 Feb 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly, Md. 20785 VILLAM 1304CE 9 Hos 32. Registrar's Signat 31. Date filed (Month, Day, Year) State 22 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>0</u>8 Day Month **02** Physician/ 2011 \mathbf{A}^{M} 8:40 JOHN PAUL TOKARZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT ST. MICHAELS 23868 NEW LAND DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours 10/27/1914 96 PA **Director** 413-10-4310 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location at Director Examiner must be notified 1 Yes 2X No ST. MICHAELS MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Funeral 23a UNITED STATES 21663 23868 NEW LAND DRIVE items ? hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ▼ Yes 2 No If Yes, Give þ 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 XWidowed 4 Divorced Year or Dates. event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) 12College (1-4 or 5+) PHOTOGRAPHIC IMAGING **EXECUTIVE** marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F of Health and Mental of Health and Mental fitem 27 is marked rother traumatic ev ပ JULIA RYCZAK JOSEPH T. TOKARZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3937 COL. ELLIS AVENUE, ALEXANDRIA, VA J. PATRICK TOKARZ, MD / SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JOSEPH'S CEMETERY 02/12/2011 CORDOVA, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ rai Medical resulting in death) Due to (or as a consequence of) Examiner eave eatwe Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical COVS ensi or P.O. Box 68760 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tibrillation 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has ; page 2 s autopsy performed death' 1 ☐ Yes 2 ☐ No certificate Yes 2 No ; After this certification funeral director, p Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{PResidence} \) 6 \(\text{Other (Specify)} \) ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 Tyes 2 🗌 No n 24 hours after death. The Funeral Director: A pleted filled in by the funeral pleted filled fi 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practioner: To the best of my knowledge, de within 2 To the F att. Scourned at the time, date and place, and due to the gauss (s) and manner as stated 29d. Date signed (Month, Day, Year) 02-09-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Cynwood Dr Easton md 21601 DO RUSSell A Schillin 10+VA 31. Date filed (Month, Day, Year) FEB 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Ar State of Maryland / Department of Health and Mental Hygier Certificate of Death

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Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) Andrew Clifford Thomas 2. Date of Death Month Day Year February 20, 2011 3. Time of Death 1005 hrs 4c. County of Death 4c. County of Death 4c. County of Death													
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ryland tonce.	MD Anne	Arundel	E	ldgewat		0f. Zip Code				10g. Citize	n of What		21	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	212 Grand Vie	ew Avenue			- ["	210	37				ed St		•	
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Ball permit Depart Impo	21. Signature of Funeral Serv	1	Sim				-	Home	P.O.	Box 1	100.	Owi	ngs. MD	
Physician	Kyle S. Simons M01206 Rausch Funeral Home P.O. Box 100, Owings, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and													
Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease Atherosclerotic Cardiovascular Disease													
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Box 68 le death cert the attendin the for use a	1 Yes 2 No 9	Jakanum -	nant at time of d	death 5	Other	(Specify)				ĺ				
J. Box 68 the death certification by the attending ached for use as Physician	Part il. Other significant con	3 0116		resulting in th	e unde	erlying cause o	given in Par	t I.	23e. Did	tobacco us	se contribu	te to th	e cause of death?	
of det									1 Y	es 2 🗸	No 3	Proba	bly 4 Unknown	
Records, The law requires fricate has been sig									24a. Was	psy	prio	r to co	psy findings available mpletion of cause of	
leco he lav ate has age 2 s									perf	ormed?	dea			
ician: Ticital Riccian: Ticital: Ticita	25. Was case referred to med						of Death (ly one)					
Physici r this o	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie		BOA			Home 5				Scene	
n of ding P. h. After funers	27. Manner of Death 1 X Natural 5 P	28a. Dat (Mon	e of Injury th, Day,Year)	28b. Time	of Injur		ry at Work? Yes 2	i	8d. Describe	now injur	y occurred			
Siol Aften r death ector: ector: by the	2 Accident	vestigation 28e Pla	ice of Injury - At	home, farm, st	treet, fa				8f. Location	(Street and	d Number o	or Rura	al Route Number, City	
Division or spital or Attending yours after death. neral Director: After filled in by the fune. Certification:	3 Suicide 6 Could not be determined (Specify) or Town, State)													
Hospi 24 hou etely fil														
To the Ho within 24 To the Fu completely	one) 2 Medical E	and manner	stated.	and/or investi	yation,	29c. Licens		Alleu at t	ne ume, dat				h, Day, Year)	
2	2-b). Signature and title of cer	D. I.	0 a			O.C.				1	uary 21,			
	30. Name and address of per	on who completed ca	use of death (Ite	m 23a)						1	, = -1			
	Margarita Korell MD				W. B	Baltimore S	treet, Ba	ltimore,	, MD 212	23				
State		ar) 32. F	Registrar's Signa	1	r									
Registra	FEB 25 201	1 Ceneur	1 12. 14	back										

Christopher Ala		ototo ot the year a partition	nt of Health and Mental e of Death		2011 g. No.	0 7 0 8 3
Physic Medical Exam				Month February 1		1423 hrs
		4a. Facility Name (if not institution, give street and number) 4451 23rd Parkway # 001	4b. City, Town, or Location of D Temple Hills		4c. County of Death Prince George	
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		N 65	-1966 Co	thplace (State or gn untry) DC
Maryland 28a-f show any d at once.	for		e Hills			10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Il Director	10e. Street and Number 4451 23rd Parkway, Apt. 1	10f. Zip Code 20748		g. Citizen of What Cou	
er death , or iter	F	1 X Never Married 2 Married 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No specify:	uerto Rican, etc.)	White, etc.	
15-0036 filed within 72 hours aft I Hygiene, d other than "natural" s, the Medical Examine	Completed		cedent's Usual Occupation (Give kind ring most of working life. DO NOT use ${ m Clerk}$	e retired)	16b. Kind of Business/	Government
	m	17. Father's Name (First, Middle, Last) Robert B. Trueheart	Barba	lame (First, Middle, M ra Johns	on	
MD nd 2 sho alth and m 27 is	7	Barbara Trueheart/mother 38	Mailing Address (Street and Number 05 Thornwood R			, MD 20784
Baltimore, WI permit. Pages 1 and 2 and 2 bepartment of Health a Important: If item 27 injury or other traum		1 X Burial 2 Cremation 3 Removal from State cremator	or other place)			1, Marylan 20746
			Cedar Hill FH,			
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Sharp Force Injuries Due to (or as a consequence of):	miler file mode of dying, soon as cardi	ac or respiratory arrow		Between Onset and Death
ed - nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):				
760, icate be executed physician and the burial - trans	edical	d. UNPENDED AMENDED			23d. Date of deliven	
OX 68' eath certiff	Physician/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 2 Unknown 2 Unknown 2 Unknown 2 Unknown 3 Unknown 2 Unknown 3 Unkno	Fetal death 3 Ectopic pro	egnancy		y Day Year
cords, P.O. B law requires that the d has been signed by the 2 should be detached		Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	1 Yes	pacco use contribute to 2 ✓ No 3 ☐ Prot	pably 4 Unknown
of Vital Records, ng Physician: The law requir Wher this certificate has been s meral director, page 2 should I	Completed by			24a. Was at autops perform	y prior to o ned? death?	stopsy findings available completion of cause of
Ital Reciding The scertificate rector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outp	26.Place of Death (Chartent 3 DOA Other No.		Residence 6 🗸 Other	r: Scope
n of Vit ding Physic L. After this funeral dir	5.	1 Yes 2 No 1 Injury 28b. Tir	ne of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
Division or Attendin ours after death.	Certification:	1 Natural 5 Pending FOUND: Fob 13, 2011 FOUN 1400 h 3 Suicide 6 Could not be	rs Tes 2	28f. Location (St	reet and Number or Ru	ral Route Number, City
Div pital o ours aff ieral D	Certi	4 Homicide determined (Specify) Found at home		or Town, Sta 4451 23rd Park	ate) (way # 001, Temple	Hills, MD
Division To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invalidation and manner stated.	estigation, in my opinion, death occurr		nd place, and due to th	e cause(s)
	Σ	29b. Signature and title of certifier , , , , , , , , , , , , , , , , , , ,	O.C.M.E.		29d. Date signed (Mo. February 14, 201	
Ψ.		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W Bal	timore Street, Baltimore, MD	21223	**	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Februar 2:49PM Elizabeth Umphries 2011 Anna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Charles Medica Civista La 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗓 F Hours (Month, Day, Year) 03/06/1920 Director 579-18-8267 90 Pennsylvania Usual Residence of Decedent show 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sh notified a 1 Yes 2 X No Marvland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 9 "natural", or items 23a or Funeral 20659 USA 39545 Mason Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 ☑ Widowed 4 □ Divorced Year or Dates er than "natur, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker and Mental Hygie is marked other Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Francis Jennings Anna Elizabeth Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 2404 Spring Lake Ct. East, Gambrills, MD 21054 John R. Umphries/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2XXCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-EcholsCrem 02/27/2011 Charlotte Hall, MD ure of Funeral Service Licen 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO817 MD 20622 Three Notch Rd., Charlotte Hall, 30195 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran attending physician Physician/Medical death certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) ☐ Pregnant :
☐ Unknown signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>^</u> Records, 1 Yes 2 → No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No page 2 autopsy performed? certificate has Yes 2 ANG Physician: Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After Hospital or Attending injury 1 Matural 5 Pending n 24 hours after death. le Funeral Director; Afte pleted filled in by the fun Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signatu who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

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			For State					Health and M		001	1	07005
		_	state Registra MEND#20bperFH 1. Decedent's Name (First, Middle, Las		,MbCo	Cer	tificate of	Death	2. Date of Dea	Reg. No.	Apple Time	0/000
	Physicia		VoucA	VALL	.10	5				04 20	rear_	3. Time of Death
	 Medic Examin 		4a. Facility Name (if not institution, give	street and number)			4b. City, Town,	or Location of Death		4c. County o		
·			Howard County G		<u>. </u>			Columbia			How	
2.44	Funeral Director		5. Social Security Number 6. Se 1	ex 7. Age □M2KLF	e (In yrs. la 86	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day 02/13	Year)	9. Birthpl Count	lace (State or Foreign ry) Greece
			Usual Residence of Decedent		80				02/13	7/1724 [Oreece
	/land f sho ed at	tor	10a. State 10b. County		10c. City	y, Town or Lo					10	0d. Inside City Limits
	e Mar r 28a- notifi	Direc	Maryland How	ard			10f. Zip Code	llicott Ci		10g. Citizen of Wh		1 🗌 Yes 2 🗓 No
	with th	Funeral Director		apple Lane) <u>.</u>		l loi. Zip oode	21042	1	Tog. Citizen or vvi	u.s	
	eath v	Fune	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13. \	Was Decedent of	Hispanic Origin? (Spe ban, Mexican, Puerto	cify Yes or No-	14. Race	- America	an Indian,
36	after d ", or i		1 Never Married 2 Married	1 Yes 2 X	No		Yes 2 💢 N		nican, etc.	Black, Specify:	White, e	
Maryland 21215-0036	atural	Completed by	3 X Widowed 4 Divorced 15. Decedent's E	Year or Dates.			dent's Usual Occi			16b. Kind of Bus		White
215	n 72 h e. ian "n Medi	dmo	(Specify only highest gra Elementary/Seconday (0-12)		i+)	(Give I	kind of work done O NOT use retire	e during most of worki d)	ng	U.S. De		
2	ygiene ygiene her th	Be Co	12				Admini	strator			ense	
and	ntal H red ot eed ot	To B	17. Father's Name (First, Middle, Last) Patan M.	atsokopetr	1011			18. Mother's Name		^{Maiden Surname)} a Farmak	i	
Ž	ould but Me		19a. Informant's Name/Relationship (T)		ioa	19b. Mailir	na Address (Stree	t and Number or Rura				ode)
Š	d2shalthal		Maria Turner - D	aughter			-	le Lane, E				
ore,	e 1 an of He If item or othe		20a. Method of Disposition 1 汉 Burial 2 □ Cremation 3 汉	Removal from State		emetery, cren	sition (Name of natory or other p	lace) Uhn		20c. Location - C	•	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (Specific	(y)	Arl	ington	Natl. (Cem. 2/25/	/2011.	Arlingto	n, V	irginia
Bal	permi Depar Impo any ir once.		21. Signature of Funeral Service Lice s	10 #10	- ۱۹							Home, Inc. g, MD 20904
			23a. Part 1. Enter the disease, or compshock, or heart failule. List only o	olications that caused	the death							Approximate
	nysician/	0.1	Immediate Cause (Final disease or condition	DN	FU	non	A					Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequ	ience of):	A	INFER	T/12./			
		er	Cequentially list conditions, if any, leading to immediate	Due to (or as			71	111111	100		-	
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	executed ian and urial-tr	al Ex	resulting in death) Last	Due to (or as	a consequ	ence of):						
09,	eath certificate be e attending physici d for use as the bu	dice		d							\pm	
Box 68760	certific nding p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of <u>pr</u> egna	ncy				23d. Date	of delive	erv
30X	leath o	icia	in the past 12 months? 1 Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Description of Ectopic pregnated Description of Contract of Contra			Mont		Day Year
P.O. E	that the des ned by the a detached f	Phy	9 Unknown Part II. Other significant conditions or		ut not roo	ulting in the u	underlying course	given in Part I	00- Did t-	bacco use contrib		a naver of death?
σ <u>,</u>	es tha signec	d by	STROKE		at not 163	arting in the c	macriying oddac	giveir ii v care i.				ably 4 Donknown
of Vital Records,	requires the been signed should be a	Completed by							24a. Was a	an 24b. We	ere autop	psy findings available
Sec.	The law cate has page 2 a	omp							autop perfor 1 🗌 Yes	med? de	ath?	npletion of cause of
a	ıysician: T is certifica director, p	Be C	25. Was case referred to medical examiner?				26.	Place of Death (Check		2 12 110	_ 103	2 12 110
Ξ	Physic this ce ral dire	은	1 ☐ Yes 2 ☑ No				nt 3 🗆 DOA			ence 6 Other		
n of	ding F h. After t funera	:ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of inju (Month, Day		28b. Time of injury	wo	ury at ork? ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred		
Division	r Attending F ter death. rector: After i by the funera	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inju						treet and Number	or Rural	Route Number,
Div	ital or irs after all Direction	S S		building, etc	с. (Бреспу) 			City or Town	n, State)		7
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 25 hours after death. The this certificate has been signed by the attending physici to the theoret preceder. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2 Medical Exami	iner: On the basis of e	xamination	and/or inves	tigation, in my opi	ne, date and place, an nion, death occurred at the time, date and place	the time, date ar	nd place, and due t	o the cau	se(s) and manner stated.
	To the within Jo the comple	Σ	only one) 3 L Certifying Nurs 29b. Signature and title of certifier	Id. 110	pest of my	/ Kilowieuge, i	29c. Licer	nse number		29d. Date signed (Month. D	Dav. Year)
	2		PACADO	y mil			0	>078		Feb, U	12	011
			30. Name and address of person who of			23a) (Type, F	Print) KE	1 TIMO	4 5	EHM	0	/.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 02 Physician/ 2011 6:15 PM Vann <u>Margaret</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number Funeral Days Months 01^(Month, Pay, Year) North Carolina Director 83 239-66-8823 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director Yes 2 No Washington DC None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1710 Frankford Street 20020 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No 2 Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 K No Specify: If Yes, Give 3 Midowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 9th grade College (1-4 or 5+) Federal Government Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of မ Sampson Beard Mary Bunning 1 and 2 should b if Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Frankford St., SE Washington, DC 20020 Grady L. Vann/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/19/2011 Clinton, NC Hillcrest Memorial 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ LNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner VASCULITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -ALURE HEART attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): CHRONIC Physician/Medical 741W RE The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Month Day Pregnant at time of death Yes 2 No ed by the detached q 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed within 24 hours after deam.

*To the Funeral Director: After this certificate is completed filled in by the funeral director, pag. 1 Yes 2 No Yes 2 No I or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 10 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D044957 FEBRUARY 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randall Wagner 7600 Carroll Avenue Unit 1500 Takoma Park, MD 20912 31 Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

WALKER, TAMES M 451362 Baltimore, Marvland 21215-0036

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		Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of L	, cair	2. Date of Dea	Reg. No.) [3. Time of Death
Physic Med		James Earl Walker					JANUAR	y 25	2011	7:12 AM
Exam					4b. City, Town, or				nty of Death	
,		CIVISTA MEDICAL CET		hh afa i sh	If Under 1 Year	lata If Under 24 Hrs.	8. Date of Birt		4ARLL	blace (State or Foreign
Funera Directo	_	425-23-4690 1	je (In yrs, last birt 48	Yrs.	Months Days	Hours Min.	(Month, Day 7	Year) 1962	Coun	try) tiss. Ms.
d worth	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Loc	cation				1	0d. Inside City Limits
lanylar Sa∽fsł Milied	Funeral Director	Maryland Charles	Wald							1 🎛 Yes 2 □ No
the M	قَ	10e. Street and Number	Wald	OLL	10f. Zip Code	-		10g. Citizen o	of What Cour	ntry?
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r deat or iten niner r	by Fu			13. V	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,	
rs afte	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	140	1	I ☐ Yes 2 👿 No	Specify:		Spec	ify: Blad	ck
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ithin / iene.	S	Elementary/Seconday (0-12) College (1-4 or 1)			O NOT use retired) Equipmen :	t Operato	or	Arling	ton Co	ounty Gov't
illed wall Hygin outher vent,	l e	17. Father's Name (First, Middle, Last)				18. Mother's Nan				
yldi lid be Menta narkec	٩	Harzeete warker				Mary Pa	ayne			
If c, INIAI yially A LAIS-DOOD 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) Karen Walker / Wife	19b 212	o. Mailir 24 (ng Address (Street a	and Number or Rui	ral Route Numbe istrict	r, City or Town Height	s, State, Zip (Code) 20747
1 and f Heal item 2		20a. Method of Disposition	20b Place o	f Dispo	esition (Name of	;	Date	20c. Locatio		
Page nent o ant: If Iry or		1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Silve Miss	ry, cren er (Lona	natory or other plac Creek ary	2/3	/2011	Jackso	n, Ms	
permit. Page 1 a Department of H Important: If ite any injury or ot	5	21. Signature of Funeral Service Licer e		22	Name and Address Alexander 5538 Mar	s of Facility	, P.A.	a + 1 1 1	o Md	20747
	2)	23a. Part 1. Enter the disease, of complications that cause							2, Mu.	Approximate
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ed	Examiner	if any, leading to immediate Due to (or as Cause (Disease or linjury	a consequence	Of):						
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ate be e	Physician/Medical	d								
ertifica ding p	/We	IF FEMALE: 23c. If yes, outcome	of pregnancy					004	Date of deliv	
death of	iciar	23b. Was decedent pregnant 1	2 Fetal deat		Ectopic pregnanc Other (specify)	y			Month	Day Year
the date by the tachec	Syyc	9 ☐ Unknown 9 ☐ Unknown							_	
es that signed lbe de	<u>۾</u>	Part II. Other significant conditions continuously to death is	out not resulting	in the u	inderlying cause giv	en in Part I.				ne cause of death? bably 4 Wunknown
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vical r ysician: T s certifica director, p	Be C	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che		2 (4 110)	1 103	Z III II
Physic this ce al dire	은	1 ☐ Yes 2 No 1 ☐ Inpat	ient 2 ER/O	utpatier Time of		4 ☐ Nursing F	lome 5 Resid)
ding P th.: After t	cate	1 □ Natural 5 □ Pending (Month, Da 2 □ Accident Investigation		injury	work	/ at ? Yes 2 □ No	28d. Describe h	low injury occ	urrea	
VISION or Attendii fter death. irector: At	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuding, et	ury - At home, fa	arm, stre	eet, factory, office		28f. Location (\$		nber or Rura	Route Number,
pital or ours aff				da 441- 4						- d
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of Control only one) 3 Certifying Nurse Practioner: To the	examination and/o	or invest	tigation, in my opinic	on, death occurred	at the time, date a	ınd place, and	due to the ca	use(s) and manner stated.
To the Vithin To the Comp	1	29b. Signature and title of certifier	. 0		29c. License			29d. Date sig		-
\$ 2			mp			w 20075	15	2	14/201	1
1		30. Name and address of person who completed cause of c	D. 2001	(Type, F	erint) ENTURY A	BOULEVAR I	SUITE	200 0.50	MANTA	WN MD 20874
St	ate	NA POLE ON MAG PANTAY III, M	ar's Signature				, 2 ,	- Now J. Compos		
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	cal Helen G. White 102 7 2011 16:20 P														
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Medic Examin				give street and nurr		ıııe		4b. City, Town	or Location of Death	1 1/2-		County of E		-2.0	
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Funeral Director		5. Social Security No. 401-24-81	10	5. Sex 1 □ M 2 🔀 F		n yrs. las 90	t birthday) Yrs.	If Under 1 Yes Months Day		8. Date of Bir (Month, Da	ay, Year)		Birthplace Country) entucl	(State or Foreign	
nd how at	r	Usual Residence of 10a. State	Decedent 10b. County		1	0c. City,	Town or Loc	ation					10d. ln	nside City Limits	
larylar 3a-f sl ified	Director	MD	Prince	George'	s	Hyat	tsvil	le					1	X Yes 2 □ No	
the M	l Dir	10e. Street and Nur	nber					10f. Zip Code)		10g. Citiz	en of What	t Country?		
s 23a sust b	Funeral	6710 Park	wood St	reet				20784			USA				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertla Hygiene. Inportment of Health and Mertla Hygiene. Inportment of Health and Mertla Hygiene. and the man Z1 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 — Widowed		12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 ⊈xNo e		If	Vas Decedent o Yes, specify Cu	Hispanic Origin? (Spuban, Mexican, Puerto No Specify:	pecify Yes or No- po Rican, etc.)		Black, V	American Ind Vhite, etc. Black	n, nait	
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12 should alth and N		19a. Informant's Na Francis N							et and Number or Ru Ave., Tamp						
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mit. P partm portar / injur		21. Signature of Fu			. 0/	licti			dress of Facility Ma	arshall-	Marcl	h Fun	eral I	Home	
De Im			WU_	Mall	W	•••	4.	308 Sui	tland Road	l Suitla	ind, l	MD 20	746		
Physician/		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition	rt failure. List or (Final	complications that only one cause on ea	caused that had been been been been been been been bee	ne death.	Do not ente	r the mode of d	ying, such as cardiac	or respiratory a	rrest,		Inte	oroximate erval Between set and Death	
Medical Examiner		resulting in death)		Due to	or as a c	conseque	ence of):	7							
Examine	Ţ.	Sequentially list co	nditions,	b	1	ne	22	na		A					
executed ian and irial-transit	Examiner	If any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate rlying iinjury s	o. 21	lex	conseque	200	nte	Lina	115	le	ed	4_		
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sician: The law r certificate has b irector, page 2 sl	Completed		110							perf 1 🗌 Yes	opsy formetra 2 No	dea		tion of cause of	
Physician: this certific ral director,	Be	25. Was case referr examiner? 1 Yes 2	ed to medical No	Hospital:					Place of Death (Che Other:						
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or Attent after deat Director: in by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investig 6 Could n determi	ot be 28e. Place	of Injury		ne, farm, stre	et, factory, office		28f. Location City or To	(Street and wn, State)	Number o	r Rural Rout	te Number,	
To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After the completed filled in by the funeral	Medical (,	Medical Ex	caminer: On the bas	sis of exa	mination	and/or invest	tigation, in my op	me, date and place, a sinion, death occurred	at the time, date	and place,	and due to	the cause(s)) and manner stated.	
To the within To the Comple	Ž	only one) 3 29b. Signature and		nurse Practioner:	io the be	est of my	knowledge, c		t the time, date and planse number	ace, and due to t			fonth, Day	Year)	

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)
FER 2 2 2011 State
Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Demetrius Catevenis 3001 Hospital Drive Cheverly, MD 20785 32. Regist ar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	State of I	Marylan	d / Depa	artment c	of Health	and N	lental Hy	_	0 1 1	0 = 0	
		State Registrar			Cer	tificate c	of Death	1		Reg. No.	2011	U/U	83
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Funeral				Age (In yrs. Ia		If Under 1 Y	ear If Und	ler 24 Hrs.	8. Date of Bir	th	9. Birl	thplace (State	or Foreign
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nd how] _	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Inside C	itv Limits
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or 28	اقًا	10e. Street and Number				10f. Zip Coo	de			10g. Cit	izen of What Co		
s 23a	Funeral Director	6521 Medwick Dr	rive			2078	3			Unit	ed Stat	es	
death item ner m		11. Marital Status	12. Was Deceder Armed Force	s?		Vas Decedent Yes, specify (cify Yes or No- Rican, etc.)		14. Race - Ame Black, White		
after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 👿 Widowed 4 ☐ Divorced	If Yes, Give		1	□ Yes 2 X	No Speci	ify:				lack	
hours natura ical E	Completed	15. Decedent		3.	16a. Deced	ent's Usual Oc	cupation			16b. Ki	ind of Business	Industry	
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ould b d Mer mark matic	-	James Robinson 19a. Informant's Name/Relationship			L				aylor N			0.11	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Principartur: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ton (son)		Beech					Town, State, Zip. 1D 20721		
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Page nent c ant: If		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		ate MD	Vetera	natory or other ns Cem	etery	2/28/	2011	Che1	Ltenham,	MD	
permit. Departr Imports any inju		21. Signature of Funeral Septice Lic	ensee								Funeral		
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		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	ly one cause on each	line.			dying, such a	as cardiac c	r respiratory ar	rest,		Approxima Interval Be	tween
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ate be executed physician and the burial-transit	dical	8	d										
eath certifica attending pl for use as tl	Physician/Me	IF FEMALE:	23c. If yes, outcon	me of pregnar	ncv								
atten atten for us	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		th 2 🗆 Feta	I death 3 🗌	Ectopic pregi Other (specifi				'	23d. Date of del Month		Year
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quires en siç ould b	Completed by	Breast Cancer							1 🗆	Yes 2	□ No 3 □ Pi	robably 4 🐴	Unknown
law re nas be	nple	Diabetes							24a. Was auto	psy	prior to o	topsy findings completion of c	available cause of
cate h									1 \(\sum \) Yes	ormed? 2 🔼 No	death?	2 🗆 No	
certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Other: 🕶	. '					
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit									City or Tov				
Hosp 24 hor Fune sted fi.	Medical	(Check 2 Medical Exa	Physician: To the best aminer: On the basis o	of examination	and/or investi	gation, in my o	pinion, death	occurred at	the time, date a	and place.	and due to the o	cause(s) and ma	anner state
ithin 2 o the	Š	only one) 3 Certifying N 29b. Signature and title of certifier	Nurse Practioner: To the	he best of my	knowledge, d		at the time, da ense number		e, and due to th		and manner as e signed (Month		
م) حاد			John	p/-)		6833				8–2011	,,/	
1.7		30. Name and address of person wh	no completed cause o	death (Item	23a) (Type, Pı								
3		Lemoll Johny,	C.R.N.P	15	245 Sh		ove Rá	l. Sui	te 130	Roc	ckville	MD 2	0850
Stat		31_Date filed (Month, Day, Year)	32. Regis	strar's Signati	E.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 16/2011 Physician/ 4:20 РМ B. Warren Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number Sex 1 M 2 D F 8. Date of Birth 7. Age (In vrs. last birthday Funeral 6 29 1926 239-44-1779 84 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at or 28a-f show 10a State 10c. City. Town or Location Director 1 Yes 2 □ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1923 Allendale Court 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. Army 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) Private College (1-4 or 5+) Brick Mason Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Helen Smith Tom Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1923 Allendale Court, Hyattsville, Maryland 20785 Ora B. Warren/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 3 Removal from State 1X Burial 2 Cremation Veterans Cemetery 03/02/2011 Cheltenham, Maryland Donation 5 - Other (Specify) Synature of Funeral Service 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner P Sequentially list conditions. Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the a 9 Unknown 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed' 1 Yes 2 No After this certificate 1 ☐ Yes 2 [25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 410 1 Tes မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 1 \sum Yes 2 🗆 No Investigation Accident
Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year) FEB 2 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 6:11AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 5. Social Security Number ^{(In yr} 82 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 F Days Months Jan. 16, Virginia Director 579-42-1180 1929 Usual Residence of Decedent or 28a-f shov 10b. Count ä 10c. City. Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified MD Prince Georges Bowie 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16104 Alderwood Lane 20716 Funeral USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black "natural", Specify: 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) Corego (1-5 or 5+) Federal Govt. Cryptologist Be 17. Father's Name (First, Middle, Last)
Joseph Giles 18. Mother's Name (First, Middle, Ma Lucille Riddle Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 Terrence G. Augustus/Son 16104 Alderwood Lane Bowie, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date injury or Arlington, Virginia Arlington National Cem. 3-8-2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pridgen Funeral Service, PA 21. Signature of Funeral Service Licer Lanham, MD 9013 Annapolis Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 2 No as been signed by the 2 should be detached g Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an certificate has autopsy prior to completion of cause of death? page 2 No Yes 2 No 1 Ves 25. Was case referred to medica funeral director Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral D To the Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Get trying Prijstclain. To the best of trijy Ninwedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. Ste E. Crofton, MD 21114 M.D. 1302 Cronson Simita Talwar 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

FEB 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GRACE MAE WATSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STO albo 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Septh, Day 2 (ear) 192 Could. 212-36-6448 88 Days Min 1 🗆 M 2 🗶 F Director Yrs Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Md. TALBOT McDANIEL 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9361 NEW ROAD U.S.A. 21647 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc Completed by ☐ Yes 2 🔀 No Yes, Give "natural", or 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH CARE NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ AWY GLADHI LL EARL M. KEPLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9363 NEW ROAD, McDANIEL, Md. 21647 SANDRA E. KLUNK / NEICE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OLIVET CEWETERY 1 Burial 2 Cremation 3 Removal from State 2-14-2011 ST. MICHAELS, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Harrend & Cost fowski Funeral Home P.A. Joseph m. Dsteauski C.F.S.P. p.o.Box 518 St. Michaels 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Em balis Physician/ sle cute disease or condition resulting in death) ona Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 No 1 Appatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [3 [only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 100 201

State

31. Date filed (Month, Day, Year)

32.

2011

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dennis M. De Shields M.D. 219 S. Washington St. Easton, Md. 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Warren felt Month " Physician/ 12.25 M - 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Overlea Mariner Health Care Baltimore If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In vrs. last birthday **Funeral** (Month, Day Days Hours Min. 218-44-1383 Maryland 64 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 6116 Belair Road 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

Typy Yes 2 \sum No 1965

If Yes, Give Black, White, etc. 1 Never Married 2 Married ð Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 1968 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Computer Operator Computer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Warrenfeltz, Sr. Delpha Rae Lanier permit. Page 1 and 2 should be in Department of Health and Menta Important: If item 27 is marked 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 7841 Deboy Avenue, Baltimore, Maryland Joyce Lochridge - sister altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Hope Cemetery 2-15-2011 Woodsboro, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 Maron 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the diseas, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown cate has been signated to page 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **D**atural 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pranticioner To the best of my knowledge, 20eth consend at the time date and plane, and due to the calescept and manner as state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print)
- Loch Raven Blvd,

Registrar
DHMH 17 Rev 7/2009

State

WARRY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar ngi Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Feb 13, 2011 James Bernard Wittkamp 11:25 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6326 Morning Dew Court Clarksvi11e Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Nov 25 ay 1949 61 Virginia Director 216 50 6499 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director MD Charles Waldorf 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? with. Funeral USA 20602 4386 Rock Court Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force 1 Never Married 2 Married ☐ Yes 2 XXNo Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Sales Welding Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hilda Groeninger Bernard Wittkamp or other traumatic 19a. Informant's Name/Relationship (Type, Print)
James S. Wittkamp (Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 400 Alder Trail, Crownsville, MD 21032 20a. Method of Disposition
1

→ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 4 Donation 5 Other (Specify) 2/19/2011 Clinton, MD Resurrection Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria m Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8 months Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death is certificate has been signed by the director, page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? safter death.

Director: After this certificate ! 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🚺 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) nue MD D54413 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

284

State 31. Date filed (Month, Day, Year)
Registrar

32. Redistrar's Signature

Young Lee, M.D. 5450 North Drive #140, Columbia MD 21045

FEB 1 8 2011

Eric Lamont 11-01223 Washing Ton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 13, 2011 0344 hrs **Medical Examiner** ERIC LAMONT WASHINGTON 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Indian Head Charles 4125 A Indian Head Highway If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ForeignWASH., 578-82-1216 Hours AUGUST 11, DC Months Director 44 **X**XM 2 F Yrs 1966 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location BRYANS ROAD 1 Yes XX No MD or 28a-f shuw CHARLES narked other than "natural", nr items 23a or 28a-f shm event, the Medical Examioer must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7111 GARDEN COURT 20616 UNITED STATES 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes BLACK 1 Yes 2XX No specify: 3 Widowed Specify 4 Divorced If Yes, Give Year 2 it. Pages I and 2 should be filed within 72 hours a trnent of Health and Mental Hygiene.
reant: If item 27 is marked ather than "natura. 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) SMITHSONIAN alea ... al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) EXHIBIT SPECIALIST Baltimore, MD 21215-0036 YEARS 12TH INSTITUTION 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ROMAINE R. DYSON WASHINGTON WILLIAM G. WASHINGTON Be 19a. Informant's Name/Relationship (Type, Print) (MOTHER) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7111 GARDEN COURT. BRYANS ROAD MD 2 GARDEN COURT, BRYANS ROAD, MD 20616 ROMAINE R. WASHINGTON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State JOSEPH CHURCH FEB. 21, 1 X Burial 2 Cremation 3 Removal from State pomfret, MD 2011 Donation 5 Other Specify 22. Name and Address of Facility
TERRENCE L. JOHNSON FUNERAL SE
4433 WHITE PLAINS LANE, WHITE 21. Signature of Funeral Service Licenses TERRENCE L. JOHNSON PLAINS #M00993 , MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical attending physician or use as the burial UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Vear 1 Live birth Fetal death Day detached for use as 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I signed b ģ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 🗹 Other Scene 1 🗸 Yes 2 No Fuoeral Director: After the 28a. Date of Injury (Month, Day, Year) Feb 13, 2011 28d. Describe how injury occurred 28b. Time of Injury 28c, Injury at Work? 27. Manner of Death Certification Subject shot 1 Natural 0344 hrs 1 Yes 2 ✓ No Pending 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 4125 A Indian Head Highway, Indian Head, MD determined (Specify) Multi-Family Apt. 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

2B2

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

2. Registrar's Signature

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

February 14, 2011

State

Registrar

11-01486 Eddie L. Watkins, II

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 1 1 7 0 State of Maryland / Department of Health and Mental Hygiene

		For State					Certific	ate of	Deat	h			F	eg. No.			
Physician/		. Decedent's Name	First, Middle	Month Day Year 1530 hrs													
Medical Examine		EDD]	ΙE	L.	WAT:	KINS	II						February	22, 2	011		1520 hrs
	4	a. Facility Name (if		n, give s	treet and n	umber)		4	•	own, or Lo	ocation of	f Death			c. County of Prince G		s
. 1	Ļ					1	1 1 1	the allow N		er 1 Year	If Under	24Hrs	9 Date of B			_	nplace (State or
Funeral Director	1	Social Security N 577-04-93		6. Sex	2F	7. Age (In yrs. last bir	τnday) Yrs.	Month		Hours	Min.	JAN 1			Foreign Cou	washington DC-
	t	Isual Residence of	Decedent			22					<u></u>						
any	1	0a. State	10b. County			10	c. City, Town	or Location	on							- 1	10d. Inside City Limits
	<u>.</u>	MD	PRINC	E GE	ORGE'	S	BREN'	TWOOD									1 XYes 2 No
the Maryland as or 28a-f sh tiffed at one		0e. Street and Nur 4142 BUI	-	ILL :	ROAD				10f. Zip	20772	2			_	tizen of Wha SA	at Count	try?
Ath u	1	1. Marital Status			2. Was De	cedent Ev	er in U.S.						cify Yes or N	0-			an Indian, Black,
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hours	<u> </u>	15. Decedent's Ed		city only						king life. D				100.	Tana or bas	111033711	, add if
21215-0036 July be filed within 72 hour Mental Hygene. marked other than "natue event, the Medical Expe		Elementary/Seco	ingary (U-12)		College (1-4 or 5+)		ANITO	R]	PRIVA	ſΕ	
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21215 Wental H Mental H marked c event, I	3	EDDIE L	. WATK	INS							DIA	NE M	ARTIN				
O 4 5 2 2		9a. Informant's Na DIANE W					19	7802	Address JOHN	Street a	and Num AVEN	berorRu UEG:	ral Route Nu LENARD	mber, C EN,	ner, City or Town, State, Zip Code) N, MARYLAND 20706		
ore, MCs i and 2 s of Health ar	1/2	0a. Method of Disp					20b. Place				etery,		Date	20c.	Location -	City or T	Town, State
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		1 Burial 2 2			Removal f	rom State	crema RIVE	tory or oth RDALI	erplace CRI) EMATO	RY	3/2/2011 RIVERDALE, MARYLAND					
alti mit. partm ports ury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FU												S FUN	ERAI	HOME, INC.	
ELSE OD	1	Quane Z Callow 7474 LANDOVER ROAD HYATTSVILLE,												LLE,M	<u>ARYI</u>	AND 20785	
Physician	2	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.												rt	Approximate Interval 8etween Onset and		
/Medical	1,	mmediate Cause (I				re D	isorde	r							_		Death
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876 tifficate ng phy as the h	2:	3b. Was decedent past 12 months			1 Live			2 Fet	al death	3	Ectopic	pregnan	су		Month	D	ay Year
b. Box 68 the death certife death certife oy the attending ched for use as physician	2								ner (Spe					Ш			
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d by a the		Part II. Other signi			-			ng in the u	nderlying	g cause giv	en in Pa	rt I.					he cause of death?
Division of Vital Records, P.O. Box 68 and or Attending Physician: The law requires that the death certif as the death. al Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as perfification: To Re Commisted by Physician		Cardio	omegal	y, M	<u>orbid</u>	0be	sity						1Y	s 2	No 3 [Proba	ably 4 🗸 Unknown
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Real The Page 1	51									26.Place o	(D15)	(Ob	1 Yes	2	VO 1	Yes	s 2 No
Central Ciana		25. Was case references examiner?	red to medica		spital: , 🖂					Io	or Death (Home 5	Doold	lence 6	Othor	Scope
Physical direction			2 No			Inpatient		Outpatient Time of In		28c. Injury			8d. Describe	-			dene
ling Ph After t funeral		7. Manner of Deat 1 🕱 Natural			(Mon	e of Injury th, Day,Yea	r) 20D.	. Time of it	ıjury		s 2		.ou. Describe	I I I OW II I	july occurre	· ·	
ttend Heath Heath tor:	[]	2 Accident	5 Pend	ding stigation													0:4
Vision Name		3 Suicide		d not be	28e. Pla	ce of Inju	y - At home, f	farm, stree	t, factory	, office bu	ilding, etc	C. 2	8f. Location or Town,		and Numbe	r or Rur	al Route Number, City
Division o ospital or Attending hours after death. oceral Director: Aft y filled in by the fune Centification:		4 Homicide	dete	rmined	(Specify	′)											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.		29a. Certifier 1 Check only 1 cone) 2	Certifying Pl Medicai Exa	miner:0	n the basis	of exami	knowledge, de nation and/or	eath occur investigat	red at the ion, in m	e time, date y opinion, e	e and pla death oc	ce, and d	ue to the cau the time, dat	ise(s) a e and pl	nd manner lace, and di	as state ue to the	d. e cause(s)
To To Com		29b. Signature and	title of certifie	aı er	nd manner	stated.			29	c. License	number			29d.	Date signe	d (Mon	th, Day, Year)
	1	11	1 1		//	L	_			O.C.M	l.E.			Fel	bruary 23	3, 201	1
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P	[Name and addr	-				ath (Item 23a) E xaminer		Raltin	more Str	reet R	altimore	MD 212	23			
		Melissa Bra							. Danil				-, 2 12				
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Deatl 3. Time of Death Physician/ <-YOUNG 2617 ZAMOHT 1: 15 am <u>February</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c County of Death Prince Georges Fort Washington Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Social Security Number 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Hours N. Carolina 85 250-26-6457 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 □ No Maryland Prince Georges Fort Washington 10e. Street and Number 10g. Citizen of What Country? AZU Funeral 20744 10800 Indian Head Highway H 104 death 1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2 □ No If Yes, Give 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. Institute!, or ant! fitem 57 is marked other than "natural", or ury or other traumatic event, the Medical Examin Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) U.Z.P.Z. Postal worker 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Young / daughter 1433 K. St., SE H 4, Wash. D.C. 20003 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 02-14-11 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory 22. Name and Address of Facility Strickland Funeral Services. PA 21. Signat Funeral S 20748 6500 Allentown Rd, Camp Springs, MD 23a. Past 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to raccon equance of) Examiner Singuinhelly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a detached f 1 Yes 2 G 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? To the Hospital or Attending Physician; The I within 24 hours after death.

To the Funeral Director: After this certificate h MRSA 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[Insert September 2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 7 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene 19a,25 per fh/me,2913,03/04/2011dhb
Reg. No. 07098 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Almoid ominaos 02:5 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 106 22 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1**√** M 2 □ F Months Days Hours Min. Director 214-68-4620 73 Portugal Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 □ No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Portugal <u>3000 Towanda Ave Apt 103</u> 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Divorced 4 Divorced Specify:Portugese Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Retirement Home 4yrs Landscaping 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u>Ricardo Almei</u>da <u>Julietta Almei</u>da 19a. Informant's Name/Relationship (Type, Print)

Lucia de Almeida – Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 BOOO Towanda Ave Apt 103, Baltimore, <u>Euciade Almeida-</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 2/19/2011 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or lining) Examiner Due to for as a consequence of: CERTIFICATION APPROVED BY MEDICAL EXAMINER attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Year 1 Yes 2 Unknown Yes 2 No Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 🗌 No 1 ☐ Yes 2 No eral Director: After this certific filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) xaminer? Hospital Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🗌 No 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 - Homicide determined building, etc. (Specify) within 24 hours a To the Funeral Completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 1962727 of person who completed cause of death (Item 23a) (Type, Print) St, Baltimore, MD 2120

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Bay, Year)

Greene

State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Timothy Alston Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Square HOSPITal Rosedale FRANKLIN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Hours Min 0672471957 **Director** 131-48-1685 Usual Residence of Deceden 10a. State 10b. County rral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 38 Vimy Court 21206 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) TIMOTH Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygbers. Immortant: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Driver Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Mary Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martina Jackson / Sister 38 Vimy Court, Baltimore, MD 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/07/2011 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Fundal Service bicel see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Cardiac arrest Medical resulting in death) Examiner cardiomyopath -15Chemic Sequentially list conditions, if any, loading to minisulate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or as a sonsequence of). signed by the attending physician and de betached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by renal disease. 1 Yes 2 No 3 Probably 4 Onknown page 2 should After this certificate has been arrhy th mia 24a. Was an performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗷 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ours after death
neral Director: A 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Configure Nurse Practioner: To the best of my kincielledge, death cround at the firme, date and place, and die to the name(e) and many are estate 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Quia MD BES0000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2245 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

1 X Yes 2 ☐ No

Baltimore

Marviand

14. Race - American Indian, Black, White, etc.

Transportation

Washington

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Black

U.S.A.

Specify:

DR Muhammad Fawad Taria 9000 FRANKLIN Square DR Balto ind 21237 31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) A.K.A. Gerry D. Antzoulatos 2 Date of Death ^{Day}2011 Month Physician/ 7:00 P M Antzoulatos Dionysios March 2 Gerasimos Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** November 10, 1942 Days Hours 1 X M 2 □ F 578-58-9478 Greece 68 Director Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No Potomac Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 9801 Korman Court Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 🔀 No f Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Hairdresser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dionysios Antzoulatos Simotas Sophia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene M. Antzoulatos / Wife 9801 Korman Court Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate7. Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Silver Spring, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Rockville, Inc. 300 W. Montgomery Avenue Rockville, Maryland 20850 . Signature of Funeral Service Licensee 12 MI MO 1607 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Inset and Death Immediate Cause (Final Ph_sician/ Pancreatic Cancer disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iii) ury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D51616 3/3/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Avenue #1300 Chevy Chase, Maryland 20815

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signatur

M.D.

Nelson Kalil, 31. Date filed (Month, Day, Year)

MAR 0 8 2011

State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 2011 6:37 PM John S. Armstrong Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1212 Robin Hood Circle Towson Date of b. (Month, Day, Yea If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Country) Canada 1 **X** M 2 □ Hours Year. Director 064-26-6548 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Towson MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21204 1212 Robin Hood Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Specify: White 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Veterinary Veterinarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabelle MacDonald Albert Sedford Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Kennard Ave. Edgewood, MD. 21040 Donald S. Armstrong/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 3-8-11 Timonium, MD. 4 Donation 5 Other (Specify) Dulanev Valley Mem. 22. Name and Address of Facility on Funeral Home, Inc. 21. Signature uneral/Service Licens 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prevmonia Pnysician/ disease or condition Medical resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months? 5 Other (specify) Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🖼 No မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature/and title of certifie D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Suite 4/05 Tonson MD 21204 Blac 6701 N ~ CSOn 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3:30 PM 2011 the Nine Lenne 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Baltimore City Manor VUVSING + Rebalo 7. Age (In yrs. last birthday) if U 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Months Days Hours 1 M 2 XF July 1915 215-10-6596 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ▼ No Baltimore Catonsville Maryland 10g. Citizen of What Country? 10e. Street and Number 5743 Edmondson Avenue 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White Specify: 3 N Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Mathias Ohle Ella May Heiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Frederick, Niece 2438 Quilting Bee Road Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 3/7/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Licensee Thomas Gregor 22 Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Catonsville, Maryland 21228 Morrow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one vause on each line. Immediate Cause (Final disease or condition resulting in death) 4000 teesalete Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contributa to tha cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yea 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 24 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

sete hes been signed by the ettending physicien end page 2 should be deteched for use as the buriel-trensit

Director: After this certific d in by the funeral director,

within 24 hours e To the Funerel C completely fifted

Medical

State

29a. Certifier

efter death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Department of Health en Important: If Item 27 is eny injury or other trau

Physician

/Medical

Examiner

10a. State

Funeral

Director

Peges 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or fems 23s or 28s-f show

Baltimore, Maryland 21215-0020

traumatic event, the Medical Examiner must be notified at

Funeral Director

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Completed

Physician/Medical Examiner Be Completed by Certification: To

Acypothered

Deoreeda breast cause 26. Place of Death (Check only one)

25. Was case referred to medical 1 | Yes 2 | HNO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of

28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

* 508 Cleu Brown Mary but 21061

28f. Location (Street and Number or Rural Route Number, City or Town, State)

03

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Me march (

29c. License number 01966

29d. Date signed (Month, Day, Year)

(Limanico 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

7310 Ritchie Shuare L'CLERR 31. Date filed (Month, Day, Year)

32. Régistrar's Signature

Hyperes

Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ 11:25 AM Nathan Lon Bowen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Hours Min (Month, Day, Maryland Yrs. Director 0 696-16-9590 Usual Residence of Deceden fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other than "----10d Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1 X Yes 2 No Alexandria VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 22301 401 East Alexandria Ave. #201 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Suzanne Blattberg Matthew L. Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 East Alexandria Ave. #201 Alexandria, VA22301 <u>Matthew L. Bowen / father</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) 3/10/2011 Orem. Utah Orem City Cemetery 21. Signature of Fun al Service Licensée 22. Name and Address of Facility Pierce Funeral Home, 9609 Center St., Manassas. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 33 days Immediate Cause (Final Physician/ disease or condition Extreme prematurity Medical resulting in death) Due to (or as a consequence of) Examiner 2 days Anuria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Necrotizing Enterocolitis 25 days Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Veal Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 1 Yes 2 No __ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🗶 No ျှ 1 Nation 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination allows investigation, army spinish, south the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 057151 March 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Walton M.D

MAR 0 8 201

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Benner 7:40 A M Demis C March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 6713 Edwards Avenue Windsor Mill Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
June 28, 1955 6 Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday 216-74-4760 Days Hours Maryland 1 X M 2 🗆 F 55 Director June Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits Director notified 28a-f Baltimore Windsor Mill 1 Tes 2 In No MD 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral 23a 6713 Edwards Avenue 21244 USA of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death v Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 X Never Married 2 Married be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Never Worked Never Worked Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Anvine E. Benner Lenore B. Rudisill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Valerie Tamajong-case worker 7215 York Road; Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Linens 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage LOPD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Pregnant at time of death detached 1 Yes 2 L 9 Unknown the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available has autopsy performed 1 Yes 2 No prior to completion of cause of death?

1 Yes 2 No After this certificate in 24 hours after death.

The Funeral Director. After this certification by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ARC of Ralinmore 2 I No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury accurred To the Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier vs Rajapahsen. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmore, MD. 21209 5-203 2835 Smith N.S. RajaRAKSI, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2011 The 1ma L. Bryan 12:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Ye Aug. 31, 9. Birthplace (State or Foreign Country) Maryland Social Security Number Funeral 6 Sex 7. Age (In vrs. last birthdav) 1 🗆 M 2 🗶 F Hours 579-14-4083 91 Director 1919 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X☐ No Anne Arundel Co. Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Archwood Avenue 21061 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2XXNo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 7, ment of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerical Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Nellie Baker Ernest Seymour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bonnie L. Fauntleroy/Daughter 24 Archwood Avenue Glen Burnie, MD 21061 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. tment of 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesterfield Cemetery March 9,2011 Centreville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation 2nd Ave SW, Glen Burnie, Services PA: MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISOR 2 No 3 Probably 4 Unknown 1 Yes Completed within 24 hours after death.

To the Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မြ 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
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3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carlos N. Patalinghug Sr. M.D. 3721 Potee Street Suite 6 Baltimore MD 21225

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March **Physician** Lako /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore
Vear | If Under 24 Hrs. AVE Linwood 5. Social Security Number 219 38 398 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funera! 1 M 2 □ F Days 398 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Marited Experiment must be maitlised at aprice. 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No by Funeral Director Baltimore MD NIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 USA Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Black 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Service Johns Hopkins University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) awrence Louise ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roselyn Blake Ushry Balto. m Winston Ave. SISTER 1515 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Memoria) Kandallstown. 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses 23a. Par 1. Interest disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gabem **Physician** ras disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? ieral Director: After filled in by the funera 28d, Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending 1 ☐Yes 2 ☐No within 24 hours after death. To the Funeral Director: A investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

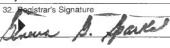
State Registrar

31. Date filed (Month_Day, Year)

301

who completed cau

29b. Signature and title of certifier



Than POON, mi

an

29c. License number

D 51088

Bathmar, m)

29d. Date signed (Month, Day, Year)

7,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 832 PM **Physician** March Ivory Lillian Bauer 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Assisted Living Bel Air Bel Air HARFORD 8. Date of Birth (Month, Day, Dec. 31, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Min. Hours 1 M 2K F Months 1915 95 Dec. Virgínia **Director** 219-05-7701 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, its Modical Examinat must be notified at 1 □Yes 2X No Director Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 2715 Bynum Hills Circle Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2€ No Specify. þ Specify: 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Clerk U.S. Government permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If item 27 Is marked other I any injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula May Radford David Hassell Underwood ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2715 Bynum Hills Circle, Bel Air, Maryland 21015 Judith Metker / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Trinity Lutheran Cem, 3-9-11 Joppa, Maryland Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENDSTAGE DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) I∐Yes 2 No 9 Hlnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 127No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a. autopsy performed? 1 ☐ Yes Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 🔲 Yes 2.0 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ASSISTED Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital

Maryland 21215-0036

Baltimore,

Hygiene. other than "natural",

sician and burial-tran physician a attending p for use as t signed by the a has page 2 s Hospital or Attending Physician: The director, After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier roun

D45344

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

622 S. UNION AVE, HAVRE DE GRACE, MB 21078

40 31. Date filed (Month, Day, MAR 0 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 11 Physician/ Month Day 2225 PM Bonnie Brown Jean 3 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Saware HOSPITal Rosedal Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🛛 F 0977271972 38 Director 219-92-9055 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 M No MD Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10500 Bird River Road 21220 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Yes 2 If Yes, Give Year or Dates. 1 X Never Married 2 Married 2 X No Maryland 21215-0036 al Hygiene. 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other trainmant. Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edward Dorothy Eberwein Aaron Brown Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Selina Westburgh, Sister</u> 1650 Grav Place, Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/08/2011 Towson, Maryland Hillton Svc. Corp. 21. Signature of Funeral Service Licensee_ 22. Name and Address of Facility Leonard J. Ruck. Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Biventricular cardiac disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner palmonary Sequentially list conditions, Examine Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit requires that the death certificate been conted Tricuspid that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Infective endocarditis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 2 1 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by drug Hepatitis abuse 1 Yes 2 No 3 Probably 4 Unknown HIV - Aids 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law page 2 performed 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of cartifier RES 0000 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR muhammad Fawad Taria FRANKLIN Square DR Balto md 21237 9000 31. Date filed (Month, State 8 Registrar

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	Physicia Medic		Decedent's Name (First, Middle, La	Frank E			2. Date of De	ath Mar 5, 2011	3. Time of Death 4:50 A M		
	Examin		4a. Facility Name (if not institution, giv Seasons Hospice		ospital	4b. City, Town, or Location	n of Death allstown	4c. County of Deat	timore		
	Funeral Director		5. Social Security Number 6. 163-20-2125		In yrs. last birthda	Months Davs Hours	er 24 Hrs. 8. Date of Bir Min. (Month, Da Aug				
	laryland 8a-f show ified at	h. h	Usual Residence of Decedent 10a. State 10b. County MD Baltir	nore City	Oc. City, Town or		timore		10d. Inside City Łimits 1 ☑ Yes 2 ☐ No		
	with the N 23a or 28 ust be not	Funeral Director	10e. Street and Number 4712 Simms Ave			10f. Zip Code	1206	10g. Citizen of What Co			
900	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eventh Armed Forces? 1 Yes 2 Note Note 1		3. Was Decedent of Hispanic 0 If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Speci	can, Puerto Rican, etc.)	14. Race - Ame Black, White Specify: WH			
1215-(s filed within 72 hour tal Hygiene ed other than "natu event, the Medical	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)		(Gi	cedent's Usual Occupation ive kind of work done during m b. DO NOT use retired) General Maintenan		16b. Kind of Business	Industry		
Baltimore, Maryland 21215-0036	should be filed within 7: and Mental Hygiene. Is marked other than aumatic event, the Me	lask	17. Father's Name (First, Middle, Last)	Charlie Bak	er	18. Mo	L Maiden Surname) ary Powasser				
Mary	d 2 should alth and Me 127 is marl or traumati		19a. Informant's Name/Relationship (ailing Address (Street and Num 112 Simms Ave Balt			Code)		
more,	permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		cemetery, c	sposition (Name of crematory or other place) ridge Memorial Park,	Date Mar 11, 2011	20c. Location - City or Elkridge	Town, State , Maryland		
Balti	permit. Pag Departmen Important: any injury		21. Signature of Funeral Sarvice Licer	Broht M	1293		mbia Pike Ellicott C				
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. End	ne death. Do not of	enter the mode of dying, such	as cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death		
90	te be executed nysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	consequence of):						
. Box 68760	he death certificate be y the attending physici ched for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	pregnancy Fetal death ime of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year		
ls, P.O.	law requires that the dea has been signed by the a s 2 should be detached fo	þ	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause given in Pa	23e. Did to	obacco use contribute to Yes 2 No 3 P	the cause of death?		
of Vital Records,	The ate h	Completed		I				psy prior to o prmed? death?	topsy findings available completion of cause of		
Vita	S S	To B	25. Was case referred to medical examiner? 1 Yes 2 No		t 2 🗆 ER/Outpa	tient 3 DOA Other: 4 D	eath (Check only one) Nursing Home 5 Resid	dence 6 □ Other Spec	jent hospice		
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	27. Manner of Death 1 N Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	oe Place of Injury			□ No	now injury occurred Street and Number or Ru	ml Poute Number		
Divi	Hospital or A 24 hours after Funeral Directed filled in by		4 ☐ Homicide determined	building, etc. (Specify)	th occured at the time, date ar	City or Tox	vn, State)			
	Го the Ho s within 24 h Го the Fur completed	Medical	(Check 2 Medical Exan	niner: On the basis of exa	mination and/or in	vestigation, in my opinion, death ge, death occurred at the time, d 29c. License numbe	occurred at the time, date a ate and place, and due to th	and place, and due to the	cause(s) and manner stated stated.		
•	. > - 0		May M.	entrais	th //tor- 00 \ T	D0043:	375	3/5/201	//		
10			30. Name and address of person who ALEN W. M. III 31. Date filed (Month, Day, Year)	completed cause of dea	2835	Smith Ave	Sufe 20	3 Palty	7170		
	Sta Registra	G	MAR 0 8 20	11 Dema	1. 4	arkel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Year P Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Health & Rehab Center **Ellicott City** Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 № M 2 🗆 F Months Days Hours Min. (Month, Day, Year) Director 218-26-6746 82 Indiana Mar 14, 1928 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery **Potomac** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11712 Greenlane Dr. 20854 U.S.A. items within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ★ Yes 2 □ No 9/21/1953 Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: WHITE 3 Widowed 4 D Divorced Completed 9/3/1955 the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha Scientist **Public Health** Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental tant: If item 27 is marked of 2 **Everett Lee Burrous** Viola Ruth Shrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Atanasoff 11712 Greenlane Dr. Potomac, MD 20854 Important: If item? any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Mar 02, 2011 4 ☐ Donation 5 ☐ Other (Spegify) Atlantic Crematory, LLC Glen Burnie, MD Signature of Funeral Service Li 22. Name and Address of Facili Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 MO053 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between ediate Cause (Final 1se are Onset and Death Physician/ avow disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed by the attending physician and stached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 5 Other (specify) detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No After this certificate 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? ျပ Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? ieral Director: A filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back Schapalh 201-109 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 Physician/ Year Eugene Bryant 2136 Medical 2011 4a. Facility Name if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown Hospital Northwest Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 □ F 248.60.1 Days Hours (Month, Day, Director Usual Residence of Decedent 28a-f show 10a, State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 10c. City, Town or Location s 23a or zoa. must be notified a 10d. Inside City Limits MD Battinore Randallstown 1 ☐ Yes 2 🏋 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Southal must items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or itel idical Examiner 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene.
27 is marked other than r traumatic event, the Me than Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Major 2tharade N Sail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bryant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 Department of Health a Important: If item 27 is any injury or other tra southall auanter anda Ustan, MD Koad 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) wings Hills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Ħ 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughor C. Greene Funeral Services Kandallstown MD 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Thysician) disease or condition Archy-thmis Medical resulting in death) Due to (or as a * nsequence of) **Examiner** artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events COCONAry Examiner Due to (or as a conseque ce of) and -transit hyperters',0 Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending I for use as as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Yes 2 No signed by the a 9 Unknown g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, as been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No bivertricular heart 24a. Was an has autopsy performe page After this certificate Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 💢 No ္ခ 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aftr completed filled in by the fun 5 Pending injury work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of q 29c. License number 29d. Date signed (Month, Day, Year) d 0468783 03/ 2011 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael L. deWit MD Northwest Hospital ER-7 Michael L. deWit 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2: 50 P M Physician/ Day 201 Year Connie March L. Barnett 4 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-24-8806 1 ☐ M 2**X**☐ F Months Days Hours Min Adr 17 18 1928 Marviand 82 **Director** Usual Residence of Decedent yous j permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other terms." 10b. County 10a. State 10c. City, Town or Location Funeral Director 10d, Inside City Limits Mary land Baltimore Towson 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 U.S.A. 20 Lambourne Road Apt. 315 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Johns Hopkins School ife DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary of Medicine Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Peter Loiero Mary Giralico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1 Foreston Valley Court Parkton, Maryland 21120 Joan Guanti/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)

Dulaney Valley Mem. Gardens 1 X Burial 2 Cremation 3 Removal from State 3/7/2011 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Ruck TowsonFuneral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Esquertally list established, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to ar as a consequence of): and Due to (or as a consequence of) resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death Yes 2 W 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ၉ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 29a Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date signed (Month. Day, Year) 7/04

State Registrar DHMH 17 Rev 7/2009 MD 21204

N CHARLES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUNAR

31. Date filed (Month, Day, Year)

701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 5, Physician/ 2011 1:28 РМ Medical Charlotte Chevenne Byram 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Month, Day, Year) 1951 1 □ M 2**X** F Georgia Director 252-80-9545 59 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2801 Murkle Road 21158 United States 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Deslie Cloudy Swain Mary Beatric Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 Murkle Rd. Westminster, MD 21158 Michael L. Byram / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 3/10/2011 Woodbine, Maryland 21. Signature of Funeral Service Licenses Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, M 21029 Part 1. Enter the di se, or complications that shock, or heart fail re. List only one cause in or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list condulons, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) ysician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months
1 Yes 2 No 5 Other (specify) Month Day Vear Pregnant at time of death signed by the a Yes P.O. Part II Qt exsignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: ပ္ 1 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence HOSPICE 1 Inpatient 2 I funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending I hours after death. uneral Director: Aft ed filled in by the fur 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 1105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 South Coa CENCOH, SHEUINTERU 22. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 201T 3 5:30 Michael Bentz Ам Albert Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tate Home Linthicum Anne Arundel Social Security Number 8. Date of Birth 9. Birthplace (State Dec. 26, 1952 Mary Tand If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. 1 3 M 2 4 F Director 214-54-9996 58 Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 504 Theresa Ave. 21061 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 x Yes 2 □ No
If Yes, Give
Year or Dates. 71-73 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Painter Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Geraldine F. Givens Charles E. Bentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trans 504 Theresa Ave., Glen Burnie, Maryland 21061 Geraldine F. William / Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marsh 2011 1 Burial 2 Cremation 3 Removal from State 4 🗆 onation 5 Other (Specify) Metro Crematory, Inc. Catonsville, Maryland une al S 21, Signat 22. Name and Address of Facility Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 0 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death (ancer Physician/ disease or condition Medical resulting in death) Due to (or as a ansequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impory that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician or use as the buria Physician/Medical or Attending Physician: The law requires that the death cer ificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year been signed by the should be detached Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 I/Yes Completed 2 🗆 No 3 🗖 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 autopsy performe this certificate 2 🗆 No Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 U Yes Certificate: To Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of after death. Director, After 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pendina Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours or To the Funeral L Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D39505 Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DV. Glen Burnil, m.D. 21061

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State Registrar 31. Date filed (Month, Day, Year)

305

32. Registrar's signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 550 6 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MANOR CARE noland TAB tiMORE 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours Min. Country) Director 239-12-4325 98 29 NC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 3915 Callaway Ave Apt 106 21215 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married within 72 hours after Yes 2 X No Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Seconday (0-12) the Private 12th grade Domestic na other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ္ William Lawrence Hattie Beatty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie Oliva Scott-Niece 3230 Dorithan Road, Baltimore, Md 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Donation 5 Other (Specify) King Memorial Park 3/12/2011 Woodlawn, Md of Funeral Service Licensee 21. Sign 22. Name and Address of Facility
March F/H West 300 Wabash Baltimoer, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. snock, or heart failure. List only one cause on each line Immediate Cause (Final disease or conditions) Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed' 2 🗌 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOLLAND

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011Leslie Wilbur Cabe March 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 833 Mount Vernon Court Harford Edgewood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 📈 🛣 2 □ F March I2, 260-96-9704 55 North Carolina Director Yrs 1955 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Harford Edgewood 1 Yes XX No 10e, Street and Numbe 10f. Zip Code ral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 833 Mount Vernon Court 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give 2 🗆 No しょくいん しょうり Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √ No Specify: 3 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the 12 US Navy Armed Forces Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wiley Cabe Eunice McCoy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Analyn Cabe (Wife) B33 Mount Vernon Court, Edgewood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of H Important: If it any injury or o once. 1 Burial 2 XX remation 3 Removal from State cemetery, crematory or other place, Bayview Crematory 03/04/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signat e of Funeral Service Licen 22. Name and Address of Facility Schimunek Funeral Home, Bel Air 610 W. MacPhail Rd. Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ WR Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in doub). Last Examiner Due to (or as a consequence or). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2 only one) 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) temmers Tun RD, Ba

OHMH 17 Rev 7/2009

State

Registrar

MAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Campbell 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Oct. 11, 1928 9. Birthplace (State or Foreign Country)
Jamaica 7. Age (In yrs. last birthdav) 1 X M 2 □ F Months Days Hours Min 82 106-68-4702 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XiYes 2 □ No Maryland Charles Waldorf

10f, Zip Code

1 ☐ Yes 2 🛣 No

20603

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

710

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Approximate Interval Between Onset and Death

Specify: Black

Month

1 ☐ Yes

Day

3 ☐ Probably 4 ☐ Unknown

2 □No

Year

U.S.A.

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Midical Examinar must by notified at should be filed within 72 hours after 15-0036 Maryland h and Mental h Pages 1 and 2 Health a timore, ₽ permit. Page Department of Important: If any injury or once. 0

Physician

/Medical

Examiner

Funeral

Director

For State Registrar

10a. State

10e. Street and Number

8804 Cottongrass Street

1 Never Married 2 ☐ Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💢 No

If Yes, Give Year or Dates:

Director

Funeral

Physician /Medical Examiner

> attending physician and for use as the burial-tran n signed by the a of be detached for page 2 After this certificate funeral director, page

or Attending Physician: The law requires that the death certificate be executed

has

I Director: d in by the

within 24 hours af

To the Funeral Di

completely filled in the Hospital

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be ၉

Completed by 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Tingling Campbell Catherine Ricketts ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garcia Buckley (Niece) 8804 Cottongrass St., Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Buylal 2 Cremation 3 □ Removal from State 3/8/2011 4 □ Donation | 5 □ Other (Specify) Nassau Knolls Port Washington, NY 21. Signature of Funeral Service Licenses 2 Name and Address of Facility Roy L. Gilmore Funeral Home 191-02 Linden Blvd., Saint Albans, NY 11412 23a. Part1. Enter the disease, or complications that cause. I the death. Do not enter the mode of rying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Immediate Cause (Final disease or condition resulting in death) Due to 6 r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Due to (or as a consequence of IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 | Unknown contributing to death but not resulting in the underlying cause given in Part I. Did tobacco use contribute to the cause of death? 200 1 🗆 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpationt 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Atural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 □ Yes 2 No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certi License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 1/2001

State Registrar MOL

31. Date filed (Month, Day, Year)

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		For	State of Ma	ryland		artment of H		vlental Hy	giene			
		State Registrar			Ce	rtificate of l	Death		Reg. No	2011	07118	
Physicia	an	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	eath Day	Year	3. Time of Death	
/Medic		William Pete		1		T		March		2011	10:50am [™]	
Examin	er	4a. Facility Name (If not institution, give					Location of Death	1	4C.	County of Deatl		
	- 1%	Envoy of Pikesvi 5. Social Security Number 6. S	11e 7. Age	(In yrs. las	t birthdav		sville If Under 24 Hrs.	8. Date of Bi	rth	Baltin 9. Birti	nore hplace (State or Foreign	
Funeral Director		-	TM 2□F)5	Yrs.	Months Days	Hours Min.	(Month, Da		Co	untry) MD	
D .		Usual Residence of Decedent						0411.14				
show	_	10a. State 10b. County		10c. City, T	Fown or L	ocation					10d. Inside City Limits 1 ☐ Yes 2X No	
ne Ma 8a-f s atifles	Director	MD Balti	more	Pi	.kesv	1			45 000			
after death with the Maryland or Items 23a or 28a-f show miner must be notifled at		10e. Street and Number				10f. Zip Code			TUG. CHIL	zen of What Co	untry?	
eath v	Funeral	559 Sudbrook Lan	e 12. Was Decedent B	ver in U.S.	13	Was Decedent of H	21208 ispanic Origin? (Si	necify Yes or No	D- -	USA 14. Race - Ame	rican Indian,	
fter d r Item iner	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 1 🛣 N		10.	If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		Black, White	e, etc.	
urs a al', o Exam	þ	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🛣 No	Specify:		Specify: White			
72 ho natur ilical	ote	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece	dent's Usual Occup e kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kir	nd of Business/	Industry	
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lled w Hygie her ti nt, th		17. Father's Name (First, Middle, Last)				Laboror	18. Mother's Nan	ne (First Middle		Railway	<u>'</u>	
d be f antal h ed of) Be		_					•	, maraon	ourraino)		
should Me mark matic	၉	19a. Informant's Name/Relationship (ghan Type. Print)		19b. Mail	ing Address (Street		na Lenz Iral Route Numb	er, City o	r Town, State, Z	Zip Code)	
nd 2 sulth ar		Kathy McKim	Daughter		559	Sudbrook	Lane. Pil	resville	- MD	21208		
s 1 al of Hea ttern othe	20a. Method of Disposition 20b. Place of Disposition (Name of competent cremeton) or other place) 20c. Location										Town, State	
Page nent c int: If		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				Cremation	1	3/2011	На	mpstead	, MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licer	see	'		2. Name and Addre		11824	Reis	terstow	m Road	
<u>0 0 = π 0</u>		stephen W.C	durkino	Al Al-		line Fune				wn, MD	21136 Approximate	
- 5.61		23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each lir	the death. ie.	Do not er	iter the mode of dylr	ng, such as cardiad	or respiratory a	arrest,		Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hort	12 -		0515					Years	
Examiner		Due to (or as a consequence of):										
কাঁ: - সাঞ্চ	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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The law requires that the death certificate be executer ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transi	Physician/Medical	•	d									
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death certific attending p	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	□Ectopic pregnancy □ Other (specify)	/		2	23d. Date of del Month	Day Year	
w requires that the deben signed by the should be detached	ıysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time or doc								
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The law cate has b	mo;							perf	ormed?	death?	L	
slcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)			
physic this c	မ	1 ☐ Yes 2 3 00	Hospital: 1 ☐ Inpatie			ent 3 DOA Oth	4 PS Nursing F			6 □Other (Spe	cify)	
Jing F	ion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day		8b. Time Injury	Wor	yat k? Yes 2∐No	28d. Describe	how injur	y occurred		
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al or / s after il Dire	Certification:	4 Homicide	building, etc	c. (Specify)	home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical C		ysician: To the best niner: On the basis o and manner sta	f examinatio								
To the To the To the To the Somple	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Dat	te signed (Mont	h, Day, Year)	
		Joseph Has	Sino			200	061199 Suite 411		Ma	r,7,.	2011	
		30. Name and address of person who	·			, Print)	C -1 4,	757.		10-11 01	2/25/	
		Jason Black My	1,6101	1V Ch	ark.	5 3/	JUITE 160	10,100	50m	MO 21	201	

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ March Day 201^{Year} Richard Scott Curtiss 5:00A M 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 122 Cedar Hill Road Brooklyn Anne Arundel If Under 1 Year If Under 24 Hrs. . Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign . Sex 1 🛣 M 2 🗀 F **Funeral** Months Hours March 19 220-70-1642 Washington D.C. Director 53 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Brooklyn 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 122 Cedar Hill Road 21225 U.S.A Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Plumbing & Heating Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Curtiss Jeannie Heffner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Cedar Hill Road Brooklyn Maryland 21225 Mrs Kim Curtiss / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 8, 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation lleno Services PA 1 2nd Ave, SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ unmonth disease or condition resulting in death) Medical Due to (or as a c man guence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or Illijury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death
Unknown 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F 3 [only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

31. Date fited (Month, Day, Year)

MAR 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ECHO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Jast) Year **Physician** 05404 2011 arch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Itimo no If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number ast birthday) 8. Date of Birth (Month, Day, Age **Funeral** Months Days Hours Min 1 M 2 16-Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it to Medical Eventine in ust be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HealthCare stant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doroth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship 4/1en LOILINS 20b. Place of Disposition (Name of cemetery, crematory of other p Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature & Funeral Service Lice Fredhilton Poss Ballo. MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one caus on each line.

Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, hours **Physician** /Medical Examiner Sequentially list conditions, if any, is a line to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 MNo 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown tor: After this certificate has been signed by the funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? /سم / سال /ital Records, F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **2**(No 1 ☐ Yes 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) V. 1 Yes 2 No 1 Mhpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a

To the Funeral D 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie death (Item 23a) (Type, Print) Name and address of person 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

11-01605 Clarence Choate Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

natefice Choate		- For State		tificate of L		u Wenta		leg. No.	2011	0/121
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)					2. Date of Dea	ath		3. Time of Death
Medical Examin		Clarence Lee Choate					Month February			2154 hrs
		4a. Facility Name (if not institution, give street and number)		. City, Town, or Edgewood	Location of D	eath		County of Death	
		609 Edgewood Road 5. Social Security Number 6. Sex 7. Ag	e (In yrs. la:		If Under 1 Yea	ar If Under 2	4Hrs. 8. Date of B		DD/YYYY) 9. Birti	nplace (State or
Funeral Director					Months Day		Min.		Foreign	1
	-	218-40-0723 1 M 2 F Superior State	68	Yrs.			Oct.	18,	1942	^{intry)} Maryland
any	ŀ	10a. State 10b. County	10c. City, 1	Town or Location	1					10d. Inside City Limits
und show	_	Maryland Harford	Edge	ewood						1 Yes 2 X No
faryla 28a-f :	\sim L	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Coun	try?
th the Maryland 23a or 28a-f sho notified at ouce.		609 Edgewood Road Apt. 1	00		21040			USA		
h with	Funeral	11. Marital Status 12. Was Deceden Armed Forces		S. 13. Was	Decedent of Hi	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	 Race - Americ White, etc. 	can Indian, 8lack,
r deat	뒤	_	No No		′es 2 √ No	oneoif.			Specific T.fl. !	1 -
rs afte	ᇍ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15, Decedent's Education (Specify only highest grade co	moleted)	16a. Decedent's			of work done		Specify: Whi	
2 hou	Completed	Elementary/Secondary (0-12) College (1-4 or		during mos	t of working life	. DO NOT use	e retired)			
036 thin 7	힑	1		Procure	ement O	fficer		U.	S. Gover	nment
215-0036 e filed within 72 hours a ntal Hygiene. ked other than "natura ent, the Medical Exami		17. Father's Name (First, Middle, Last)					lame (First, Middle,		·	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	8	Clarence T. Choate 19a. Informant's Name/Relationship (Type, Print)		10h Mailing /	ddraes (Stra		unk) Mitc or Rural Route Nu			Zin Code)
MD 2 12 shoul th and M 1.27 is m	⊢ ∦.	Neal Lane / Executor		1			dena, MD			2.5 0000)
eal and	- 1	20a. Method of Disposition		lace of Dispositi	on (Name of ce		Date		ocation - City or	Town, State
MOFE Pages 1 nent of H nut: If it	-	1 Burial 2 Cremation 3 Removal from S	lale	rematory or othe 1top Sei		om .	3-5-11	m	wson, Ma	arvland
Baltimo permit. Page Department Important: injury or ott	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licepsee	11111	22. Na	me and Addres	s of Facility			WSOII, FIL	itytaia _
Balti permit. Departm Importm injury	- 1		ou	Mc(Comas F 17 Coke	uneral sburv 1	Home, P. Road, Abi	A. nadc	n. MD 21	.009
Physician	T	23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death.	Do not enter the	mode of dying	, such as card	iac or respiratory ar	rest, sho	ck, or heart	Approximate Interval Between Onset and
xàminer	1	Immediate Cause (Final disease a Atherosclerotic	Cardiova	ascular Dise	ase					Death
, ZXGIIIII O	-	or condition resulting in death) Due to (or as a cons	equence of)):						
	اة	Sequentially list conditions, if any, leading to immediate b. Due to (or as a constitution)	sequence of)):						
	mine	cause. Enter Underlying Couse (Disease or injury that initiated								
4		events resulting in death) Last Due to (or as a content of the co	sequence or;):						
executed an and al - transit	Medical	UNPENDED AMENDED								
60, ate be exe hysician a	릙	IF FEMALE: 23c. If yes, outcome	me of pregn	nancy				230	d. Date of delivery	
687 ertific ding p		23b. Was decedent pregnant in the past 12 months?	t time of dea		I death 3	Ectopic pr	egnancy		Month D	yay Year
Box 6876(death certificate the attending phy defor use as the b	Physician/I	1 Yes 2 No 9 Unknown 9 Unknown	it time of dea	5 Othe	r (Specify)					
that the d	된	Part II. Other significant conditions contributing to dea	th but not re	sulting in the un	derlying cause	given in Part I	23e. Did	tobacco	use contribute to t	the cause of death?
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	후	Diabetes Mellitus					_ 1 TY	s 2	No 3 Prob	ably 4 🗸 Unknown
ords, P w requires the season signs should be d	Completed						24a. Was		24b. Were au	topsy findings available ompletion of cause of
eco ne law te has ge 2 s	틹						perf	ormed? 2 ✓ N	death?	
Vital Recc ysician: The lav his certificate ha		25. Was case referred to medical	·		26. Plac	e of Death (Ch	neck only one)			
Vita	음 일	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpat	ent 2	ER/Outpatient			ursing Home 5			Scene
I Of ing Pl	٤	27. Manner of Death 1 V Natural 5 Panding	ury Year)	28b. Time of Inj	· 1 -	ury at Work? Yes 2 No	28d. Describe	how inju	ıry occurred	
sior ttend death ctor: y the	ij	2 Accident Investigation						(Ctroot o	nd Number of Du	ral Route Number, City
Division of pital or Attending Phons after death.	Certification:	Suicide Could not be determined (Specify)	njury - At no	ome, farm, street,	ractory, office	bullaing, etc.	or Town,		IIId Number of Ru	rai Route Number, City
Ospita hours unera		4 Homicide 29a. Certifier 4 Certificing Physician: To the best of	my knowledo	ne death occurre	ed at the time of	late and place	and due to the cau	use(s) an	d manner as state	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) Medical Examiner: On the basis of ex	amination ar	nd/or investigation	n, in my opinio	n, death occur	red at the time, date	and pla	ace, and due to the	e cause(s)
Son Son	₹	29b. Signature and title of certifier			29c. Licen	se number		29d.	Date signed (Mor	nth, Day, Year)
		(Valuleund)			0.0	.M.E.		Feb	ruary 28, 201	1
au./	1	30. Name and address of person who comp to cause of				-				
21,1		Laron Locke MD. Assistant Medical Ex			timore Stre	et, Baltimo	re, MD 21223			
Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registr	ar's Signatu	parke	7					
1,000		BOLD IN THE STATE OF THE STATE	10 1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5&12 Per FH G913 3/15/2011 JH State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Pasquale Caporaso March 2011 5:17 Medical Ρ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bedford Courts Nursing & Rehab. Silver Spring Montgomery 5. Social Security Nuclos 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 🕅 M 2 🗆 F Months Hours Min March 27,1920 90 Director $057 - 16 - \frac{1619}{1619}$ Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XX No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15107 Interlachen Dr. #808 20906 United States 12. Was Decedent Ever 179492 — Armed Forces? 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give 104 Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Year or Dates 1940 - 43 3 🗌 Widowed 4 🗌 Divorced Specify any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Private Sector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederico Caporaso Maria Gracia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Caporaso / Daughter 5027 41st St. NW, Washington D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory | 3/8/2011 Beltsville, MD 21. Signature of Funeral Service Licenses Rapp Fid Address of Facility Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) THEROSCHEROTTO APDIENASCULAR YOARS Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AMERY DISEASE, HYBERTENSION, HYPOUPIDEMIA, 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown DISEASE STAGE IV, ANASARCA 24b. Were autopsy findings available prior to completion of cause of death? CHENICIF 24a. Was an autopsy After this certificate perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 29c. License number 0 53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20902 SHYAMSUDAR 9801 GEORGIA AUET 117 M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 2011 Registrar DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 1: [P M 2011 Custodio orenza /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Mercy Medical Baltimore Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🔀 F Philippines Aug 10, 1951 59 Director 564-27-0117 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner is use to collined at 1 ☐Yes 2X No Director Florida Pasco Land O Lakes 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 34638 Philippines 3321 Bellericay Lane Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Filipina If Yes, Give þ 3 ☐ Widowed 4 K Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker es 1 and 2 should be filed w of Health and Mental Hygie f Item 27 is marked other tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Culala ပ Rosendo Garcia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11750 Alden Rd #106 Jacksonville, FL 32246 Rowena Custodio / Daughter 20c. Location - City or Town, State Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State Final Journey Crematory 03/09/2011 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic colon cancer resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) JYes 2 □ No 9 Unknown 9 XUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 □ Yes 2 ■ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Hospital

within 24 hours a To the Funeral D completely

State Registrar

29c. License number

29d. Date signed (Month, Day, Year)

Physician

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Mercy Medical St. Paul Place Baltimore, MD 301 Center

31. Date filed (Month, Day, Year) MAR 08

29b. Signature and title of certifier

Wong



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Crockett Susan Lynne March 8:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Elkridge 5797 Elkridge Heights Road Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 15, 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 💢 **Director** 127-48-9585 Alabama 56 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Elkridge 1 Yes 2X No Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 5797 Elkridge Heights Road 21075 USA filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married þ ☐ Yes 2 【XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 75 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Fine Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ George Richard Crockett Karolyn Clarice Gould 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5797 Elkridge Heights Road Elkridge, MD 21075 Charles W. Knaack/husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 03/05/11 Woodbine, MD 21. Signature of Funeral Service Lice Ging Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A Clarksville MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ IRRMOSIS LIVER OF disease or condition Medical resulting in death) Due to (or as a consequence of Examiner LIVER ALCOHOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ENCEPH MOPAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: မြ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Deatl Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death e Funeral Director: A bleted filled in by the fa 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Continued by the cause of the Within 2 only one) 29b. Signature a 29d, Date signed (Month, Day, Year) 04 2011 who completed cause of death (Item 23a) (Type, Print) 21045 STE 100, COLUMBIA, MD , VV MINITREL WAY 7120

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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				Registrar 1. Decedent's Name (First, Middle, Las	st)	_	Ceri	illicate or	Deaiii	2. Da	Reg.	No. 2	3. Time of I	26	
		Physicia Medic		Dolores C. Clar	rk					Mar		3 20 11	11: 4		
4	, l	Examir		4a. Facility Name (if not institution, give Stella Maris	street and number)			4b. City, Town, c		Death		4c. County of Dea			
1		Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. las	st birthday)	If Under 1 Year	If Under 2		te of Birth	g. Bir	thplace (State or	Foreian	
		Director		220-07-3701	□м 21 г		93 Yrs.	Months Days	Hours	Min. Nov	onth, Day, Ye	917 Mar	yland		
	- Du	show	or	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City	y Limits	
	Viaryla	28a-f s	Director	Maryland Anne Aru	ndel	Hano	ver						1 🗆 Yes		
	h he	a or 2 be no	al Di	10e. Street and Number				10f. Zip Code			"	. Citizen of What Co	-		
	th wit	ms 23	Funeral	6888 Ridge Road	12. Was Decedent Ev	or in LLC	12 14	21076 as Decedent of F	lianania Oriai	in') (Canait : Vo		ted Stat			
р.ш.	JUSO Is after des	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	lo	If	Yes, specify Cub.	an, Mexican,	Puerto Rican, (etc.)	14. Race - Ame Black, Whit Specify: Wh	e. etc.		
D. E.	13-70	n "nat ledica	Completed	15. Decedent's E (Specify only highest gr			(Give ki	ent's Usual Occup nd of work done	durina most (of working	168	o. Kind of Business	Industry		
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-	Maryiand 2 should be filed	marke natic	မ	Andrew Schuleupr		Т				Schatz					
2011	Ma 2 sho	Ith and 27 is r traun		19a. Informant's Name/Relationship (T) George H. Clark,	, ,							y or Town, State, Zi	o Code)		
r i	1 and	item other		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of atory or other pla	T	Date		and 21076 c. Location - City or	Town, State		
H.	Page	ment clant: If		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State (y)	Atla	ntic C	rematory	y Ma	rch 6,	2011G1	en Burni	e, Maryl	and.	
MARCH 3,		Depart Import any inj once.		21 Signature of Funeral Service Licens	(2(_)		22. 13	Name and Addre 28 Sulpl	ess of Facility nur Sp	AMBROS ring Rd	E FUNE	RAL HOME	INC ryland 2	1227	
1				23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	olications that caused t ne cause on each line.	he death.	Do not enter	the mode of dyir	ng, such as ca	ardiac or respir	atory arrest,		Approximate Interval Betw	reen	
i		ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. CONGEST			FAILURE					Onset and De	eatn	
ì	E	xaminer	,	On and the line and the line	L Duc to (or as a	conseque	ince oij.								
	Б	Ħ	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	f any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury										
	recuter	and I-trans	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a	conseque									
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09280	tificate	ng phy as the		IF FEMALE:											
Bov 69	ath cer	attendi for use		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🗶 No	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t	☐ Fetal o	death 3	Ectopic pregnandother (specify)	су			23d. Date of de Month	livery Day Ye	ear	
	the de	by the ached	hysi	1 L Yes 2 X No 9 Unknown	9 Unknown	ume or de	aui 5 🗆	Other (specify) _							
EK D	s that	gned b		Part II. Other significant conditions of	ontributing to death but	not result	lting in the un	derlying cause gi	ven in Part I.	23	e. Did tobaco	co use contribute to	the cause of dea	ath?	
2 2	equire	een si	eted							- L	1 🗌 Yes		robably 4 🗌 Ui		
- 0	e law r	ate has been signed by the attending page 2 should be detached for use as	Completed by							24	a. Was an autopsy performed	prior to death?	topsy findings av completion of cau		
LORES	an: T	certificate ector, pag	Be Co	25. Was case referred to medical				26. P	lace of Death	1 (Check only or	Yes 2		2 🗆 No		
DOLO	hysici	his cer Il direc	욘	I LI fes 2 A I NO	Hospital: 1 ☐ Inpatien			Oth	er.			6 X Other (Spec	ify) HOSPI	CE	
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	e Hospita	within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical Exami	sician: To the best of m ner: On the basis of exa se Practioner: To the be	mination a	and/or investig	ation, in my opinio	on, death occ	urred at the time	e, date and pla	ace, and due to the	cause(s) and mann	ner stated.	
4	10 th	withi To th	•	29b. Signature and title of certifier	CLNP			29c. Licens		192		Date signed (Month			
		4.1		30. Name and address of person who o	ompleted cause of dea	th (Item 2	3a) (Type, Pri	nt)				1 1/2 1			
		Cto.	0	JACKIE JONES CR	32. Figurar's			LEY RD.	TIMO	NIUM, M	D 2109	3			
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imothy Davis		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death	0712
Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	1556 hrs
		Western Maryland Regional Medical Center Cumberland Allegany	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Months Days Hours Min.	
Director		Usual Residence of Decedent	itry) MD
any		10a. State 10b. County 10c. City, Town or Location 1	10d. Inside City Limits
Aaryland 28a-f show 1 at once.	tor	MD	1 Ves 2 No
e Mary or 28s	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Countr	y?
death with the Maryland or items 23a or 28a-f sho must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - America	an Indian, Black,
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ural", miner	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Ind.	QCK flustry
72 houn "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	11-
within tiene.	Completed	12 Truck Driver Transp	contation
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)	
	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	(ip Code)
- P = = = =		Deloves Davis 20a. Meyrod of Disposition 20b. Place of Disposition (Name of cemetery, Date, 20c. Location - City or To	<u>40</u> 21207
Baltimore, permit. Pages 1 an Department of He. Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)	10. 111
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Specify: VVII 0 CLC STATE TO THE COLOR OF THE COLOR	0 House
		Think thill st. 4600 Liberty Height Ave, Bo	ito MD
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	Doda!
	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	
scuted and transit		events resulting in death) Last Due to (or as a consequence of):	
	edical	UNPENDED AMENDED	
ox 68760, eath certificate be excatending physician or use as the burial.	ŽΙ	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery	
Box 6876 (death certificate he attending phy dor use as the b	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	y Year
the dear	Physici	Yes 2 No 9 Unknown 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	a cause of death?
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of Vital Records, in Physician: The law require the this certificate has been sineral director, page 2 should b	Completed		osy findings available
Recol The law cate has	Ë	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No
tal Recian: The certificate ector, page	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other	
n of Vi ing Physi After this tuneral dir	유	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
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Division tal or Attendir s after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State)	
Ospital (ospital i hours a uneral I ly filled		4 Momicide (Specify) Jail/Penal 13800 McMullen Highway, Cumberlar 29a, Certifier 1 Certif	nd, MD
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the beautiful to the funeral director.	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated.	:ause(s)
E 2 E 3	\$	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,	, Day, Year)
		Potr Cur - Poller O.C.M.E. February 14, 2011	
31		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
	ate	31. Date filed (Month, Day, Year) MAR 0 8 2011 32. Registrar's Signatury Aparell Aparell	
Regist	rar	MAR 0 8 2017 Deneur B. Market	

OCME

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Valerie r. Durham Physician/ M 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner osedos more Franklin Square 1105 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, **Funeral** Days 1 □ M 2 🛚 F Months 6,1976 Director October 214-04-5986 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 ☐ Yes 2 🕅 No Parkville Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 3641 Double Roack Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Was Deceuc... Armed Forces? 1 ☐ Yes 2 X No Black, White, etc ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Mea one. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Theresa Swift Robert Nieman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3641 Double Rock Lane Parkville, Md. Mother Theresa Lowrey Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkville, Md. 3-9-2011 Parkwood 22. Name and Address of Facility Schimunek FunerAL Home 21. Signature of Funeral Service Licenses Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician meta disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 9 Unknown Other (specify) should be detached been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director. After this certificate has to the Funeral Director, the funeral director, page 2 s autopsy performe 2 No 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ပ္ 1 🗌 Yes 2 🔽 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Tertifying Nujee Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature an 29d. Date signed (Month, Day, Year) itle of certifier 3 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 9000 Franklin Square Drive Baltimore, MD acris Date filed (Month, Day, 32. Registrar's Signature State MAR 0 8 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year OBERT 23:45 PM MARC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A HOPKINS BAYVIEW MEDICAL 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F Months Days Hours Min Country) Maryland **Director** 219-80-2843 48 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 XYes 2 No N/A Maryland Baltimore 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21214 2300 Hemlock Avenue U.S.A. hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 A Married þ ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Greenhouse 12th. Grade Horticultural Assistant Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dobbs Marks Robert Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lopresti/Mother 21214 4506 Arabia Avenue, Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/07/2011 Baltimore MD Moreland Memorial Park 21. Signature of Funery Service License 22. Name and Address of Facility
Miller-Dippel Funeral Home, Inc.
6415 Belair Road, Baltimore MD 21206 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death shock, or heart failure List on Immediate Cause (Final O PULMONARY ARREST Physician/ disease or condition resulting in death) Medical Examiner HEMORRHAGE WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events. Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death cate has been signed by the case 2 should be detached. a | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 N N funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No ٩ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury ☐ Natural

Accident 5 Pending s after death. Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined e Funeral C Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29c. License number 29d. Date signed (Month. Dav. Year) ES-000 homas MARCH 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE. BALTIMORE KOSZTOWS 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

MAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** P^{M} Grace E. Dauster 2011 March 4, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Asbury Village-Wilson Healthcare Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🗓 F 189-14-3705 87 1923 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 U.S.A. 301 Russell Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White 9 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Thomas Henderson Margaret Whieldon Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Diana Ehmann (Daughter) 85 Lincoln St., Powell, OH 43065 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrst Mem. Park 3/8/2011 Sharon, PA 22. Name and Address of Facility
Hart Funeral Home, Inc.
3103 Lillian Ave., Murrysville, PA 15668 21. Signa are of Faneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) intestinal obstruct uto **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or sele currenquence of) Examine The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending should be detached for use as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 219 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No Oxticar 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes * 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Manper of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012452448008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14 ROBERT - BIRSCITBARGE MS 138URGULL 20847 32. Registrar's Signature 31. Date filed (Month, Day, Year) . - - -State

DHMH 17 Rev 1/2001

Registrar

Tereur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State of Market State State State State Registrer	aryland / Depa <i>Cer</i>	artment of F <i>tificate of L</i>			ene eg. No 20	11 07131				
Phy	sicia	n/	1. Decedent's Name (First, Middle, Last) Flora Mary DeCrispino				2. Date of Death March	3 ^{ay} 20	3. Time of Death 6:05 A. M				
pulling and the second	ledic amin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of Death	TIGE CIT	4c. County					
man de la companya de			Lorien Taneytown		Taneyt	OWN If Under 24 Hrs.		Carroll					
Fun Direc			1 DM 2 17 E	e (In yrs. last birthday) 1 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, May 2,	1919	9. Birthplace (State or Foreign Country) Maryland				
and show	at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits				
Maryla 28a-f	otified	irect	Maryland Carroll	Westminste	r				1 ☐ Yes 2 💢 No				
vith the	st be n	Funeral Director	10e. Street and Number 610 Woodside Drive		10f. Zip Code 21157		11	0g. Citizen of N U • S	What Country?				
land 21215-0036 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show	Examiner mu	þ	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No If	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)		ee - American Indian, ck, White, etc. : White				
2 hour "natu	edical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give F	lent's Usual Occup	during most of worki	ng	16b. Kind of B	usiness Industry				
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental hygiene. 27 is marked other than "natural", o	the M		Elementary/Seconday (0-12) College (1-4 or 5	+}	ONOT use retired) Inting Cl		E	ducati	on				
e filed v tral Hyg	event,	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M						
Aaryla should by and Mer is mark	rmatic		Harry DeCris 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a	fonzo State, Zip Code)							
	her tra		Paul Price (nephew)	yland 21157									
IMORE Page 1 a nent of H ant: If ite	y or of		20a. Method of Disposition 1	20b. Place of Disposementery, crem New Cathe	natory or other plac	ce)			- City or Town, State				
Baltimore, permit. Page 1 and Department of Hea Important: If item	ny injur		21 Signature of Europal Sandoell icenses	hwab Witzke MD. 21228									
n goe	@ O	-	1917 Chauma						MD. 21228 Approximate				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cautis to live to immediate to the line of the line of the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):												
Exami			Experience little	ryscler	otre 1	/ ascal	las De	sine	254				
pel	nsıt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	a consequence of):					11:20				
certificate be executed and inding physician and	ırıal-tra	al Exa	that initiated events resulting in death) Last C. Due to (or as a	a consequence of):									
/60 cate be	s the bu	edical	d										
Gox death the atte	ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	су			ate of delivery onth Day Year				
dS, P.O. quires that the en signed by	ould be deta	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob		ribute to the cause of death? 3 Probably 4 Unknown				
Hecords, The law requires icate has been significate has been significant has been significa	r, page 2 sn	Completed					24a. Was an autopsy perform 1 Yes 2	/	Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
VITAI ysician: is certific	directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	Oth	er: 4 Nursing Ho	only one) me 5 ☐ Resider	nce 6 🗆 Oth	er (Specify)				
On OT ending Ph eath. or: After thi	ne tuneral	Certificate: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident Investigation	28b. Time of injury	28c. Injury work M 1 🗆	y at	28d. Describe hov						
DIVISION tal or Attendir rs after death. al Director: Af	in by	Certi	3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
L ne Hospita n 24 hours ne Funeral	pleted fille	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a. Certifier 25a. Certifier 2											
To the To the	шоо	-	29b. Signature and title of certifier 29c. License number 29d. Date signed (Manth, Day, Year) 29d. Date signed (Manth, Day, Year)										
10	v		30 Name and address of person who completed gause of d	eath (Item 23a) (Type, P	rint) Poule R	& West	mil sol	n m	D 2/157				
Reç	Stat gistra		31. Date-filed (Month: Đay, Year) 32. Registre	Sarles		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							

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			State Registrar		Certificate of E	Death	Reg.	No.			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death		
	Medic		George Michael Dudley					2011	11:10 PM.		
	Examin	er	4a. Facility Name (if not institution, give street and no			Location of Death		4c. County of Death			
-			Howard Courty General His		Columbia						
	Funeral		5. Social Security Number 6. Sex. 12 M 2 F	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	ır) Coµ	hington suga		
-	Director		Usual Residence of Decedent	54 "	10.	<u> </u>	6 Hone	third states			
	und show at	ō	10a. State 10b. County	10c. City, Town of	or Location				10d. Inside City Limits		
	laryla 3a-f s ified	Director	Maryland Howard	Fllico	tt City				1 🗌 Yes 2 🔀 No		
	or 28	ᅙ	10e. Street and Number	BITICO	10f. Zip Code		10g.	Citizen of What Cou	untry?		
	with 1	Funeral	10005 Carrigan Drive		2104	2	11	nited Sta	tes		
	eath tems er mu	-un-	11. Marital Status 12. Was De	cedent Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Spec	ify Yes or No-	14. Race - Ameri			
Q	ter d	by I		2 🖾 No	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto F	lican, etc.)	Black, White			
2	ural" ural"	ted	3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or		1 L Yes 2 M No	Specify:		Specify: Wh	k		
215-0036	2 hou "nat	Completed	15. Decedent's Education (Specify only highest grade complete		Decedent's Usual Occup Give kind of work done o		16b	. Kind of Business In	ndustry		
2	hin 7 ne. than	mo	Elementary/Seconday (0-12) College								
N	d wit lygie ther nt, th	Be C	77 Fallenda Alama (First Adidda Lagh)	4 Dat	<u>a Base Admi</u>				n Technology		
anc	e file tal H ed or	TO B	17. Father's Name (First, Middle, Last)				(First, Middle, Maide	•			
ž	uld b d Mel mark natio		George Hayden Dudley			-		Manoukian			
Maryland	2 should be filed withi th and Mental Hygiene 27 is marked other th traumatic event, the		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street a				' * I		
a,	and Healt		Barbara A.T. Boyd Dudle 20a. Method of Disposition	-	005 Carriga: Disposition (Name of	-		Location - City or 1			
و	nt of nt of t: If it		1 Burial 2 🔀 Cremation 3 🗌 Removal fro	m State cemetery,	crematory or other place	e)		•			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amortant: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	. 5	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Livensee		urney Crema			<u>odbine, M</u>			
\mathbf{g}	permi Depar Impor any ir	Į.	21. Signature of Fulleral Service Liberises	MO13E1	Going Home	Cremation	n Service	P.O. Box	784 le, MD 21029		
			23a. Part 1. Enter the disease, or complications tha					JALKSVIII	Approximate		
			shock, or heart failure. List only one cause on		Interval Between Onset and Death						
	Physician/ Medical	ž X	disease or condition	d stage Lu		۷					
	Examiner		Due to	o (or as a conjequence of)							
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X Q	leath e atte	sici	1 Yes 2 No	gnant at time of death	5 Other (specify)	у		Month	Day Year		
- -	the cby the tache	Physician	9 🗆 OTIKITOWIT					!			
л Э	s that gned se de	þ	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause giv	en in Part I.		o use contribute to			
as,	quire en si	ted					1 🗆 Yes	2 No 3 Pro	obably 4 🗆 Unknown		
Vital Records,	aw rea	Completed					24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of		
Ŭ L	The la	Son					performed	? death?	2 🗆 No		
TO.	sian: ertifica ctor, I	Be (25. Was case referred to medical examiner?	/	26. Pla	ace of Death (Check	only one)				
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5	ing P	ate:		e of injury 28b. Tin nth, Day, Year) inju		vat ?	8d. Describe how in	jury occurred			
0	tend leath tor: A the f	iţic	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 No					
DIVISION OF	or At after of Direct in by	Certificate:		e of Injury - At home, farm ding, etc. (Spec <i>ify)</i>	n, street, factory, office	2	8f. Location (Street City or Town, Sta	and Number or Rura ate)	al Route Number,		
ב	pital ours a eral I		29a. Certifier 1 Certifying Physician: To the	hest of my knowledge, de	eath occured at the time	date and place and	dua to the cause(s)	and manner as stat	tad		
	e Hos 124 h e Fun eleted	Medical	(Check 2 Medical Examiner: On the bonly one) 3 Certifying Nurse Practioner	asī's of examination and/or i	nvestigation, in my opinic	n, death occurred at t	the time, date and pla	ace, and due to the ca	ause(s) and manner stated.		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	2	29b. Signature and title of certifier	and the second second	29c. License			Date signed (Month,			
			> /8		D00	71381.		03/1/2	0(1		
	INV		30. Name and address of person who completed cal	use of death (Item 23a) (Ty	pe, Print)						
	100		GRUJANA POLSANI, 57	55 Cdar L Registrar's Signature	n, Columbia	1, MD, 21	044.				
	Stat		31. Date filed (Month, Day, Year) 82.	Registrar's Sig <u>natur</u> e							
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J		Physicia Medic		Yacoub San	kis	Damir	ji							March	2,	2011	Year	8:00	РМ
11		Examin		4a. Facility Name (if not institution	, give str	eet and nun	nber)			4b. Ci	ty, Town, or				4	c. County			
70				Shady Grove 5. Social Security Number	Adve	entist			al st birthda	v) If Un	Roci	kvil		8 Date of Ris	Montgomery . Date of Birth 9. Birthplace (State or Follows)				
n		Funeral Director		219–98–8194 Usual Residence of Decedent	1 📉	M 2 🗆 F		93	Yrs	Month		Hours		(Month, Da August	15, Year)	1917	Соц	urkey	T Oroigi?
t		and show	l h	10a. State 10b. County				10c. City	, Town or	Location								10d. Inside Cit	y Limits
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14		th the		10e. Street and Number				- "	100	10f.	Zip Code	0007			10g. C	Citizen of \		•	
2		ath wil	Funeral	832 Quince		chard 2. Was Dece				3. Was Dec		2087		ify Yes or No-	-			States	
	9	er de	by F	1 Never Married 2 Ma		Armed Forces? 1 ☐ Yes 2 X No					ecify Cuba			Rican, etc.) Black			ck, White,	White, etc.	
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7	21215-0036	s filed within 72 hours after death with the Manyland tal Hyglene. Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Seconday (0-12)		College (1	-4 or 5+	-)			railo:	r				C:	loth:	lng	
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ano.	E O			1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (emoval from	1 State	1		erematory o eaven (ry	March 20	₁ 7,	Sil	ver	Spri	ng. Maj	vlano
AC.	Baltimore,	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Licenese							_		-				ille, I 20850-2	
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	09		dical		d.	_Kle	265	ich	a p	neum	onia								
	687	ertifica ding p	/Me	IF FEMALE: 23b, Was decedent pregnant	230	c. If yes, ou	tcome o	of pregna	ncy							23d Da	ate of deli	/en/	
	Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 24 hours after death certificate has been signed by the attending physiciated filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown		1 Live 4 Preg 9 Unk	gnant at			3 Ectop 5 Other	ic pregnant (specify) _	cy					onth	•	'ear
	0.	at the ed by t detach		Part II. Other significant condit	ons cont	ributing to	death bu	it not res	ulting in t	ne underlyir	ng cause gi	ven in Pa	art I.	23e. Did	tobacco	use cont	tribute to	the cause of de	eath?
	S, F	uires ti n sign	ed by	urinary	trac	t iv	rfe c	cho.	n					1 🗆] Yes	2 🗌 No	3 🗆 Pro	obably 4 🔀	Jnknown
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	ta	cian; certific ector,	Be	25. Was case referred to medica examiner?		ospital:					26. P	or.	Death (Check						
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	o uc	nding ath. :: After e fune	icate	1 X Natural 5 ☐ Pend 2 ☐ Accident Invest	ing igation	(Mor	nth, Day,	Year)	inju	ry M	worl		- 1			.,			
	Division of Vital Records, P.O.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.	Certificate:	3 Suicide 6 Could 4 Homicide deter	not be	28e. Place build	e of Injur ling, etc.	ry - At ho . (Specify	me, farm	street, fact	tory, office		2	28f. Location City or To			er or Rura	al Route Numb	er;
	۵	hours neral I	Medical	29a. Certifier 1 🔀 Certifyin	g Physic	ian: To the I	best of n	ny knowl	ledge, de	ath occured	at the time	e, date a	nd place, and	d due to the c	ause(s)	and mann	ner as stat	ed.	
		he Ho in 24 l he Fu	Med	(Check 2 ☐ Medical only one) 3 ☐ Certifyin	g Nurs e	r: On the ba Practioner:	sis of ex To the b	amination best of my	n and/or ir y knowled	vestigation, ge, death o	in my opini ccurred at th	on, deatl	h occurred at date and place	the time, date e, and due to t	and place the cause	ce, and du e(s) and m	ie to the ca	ause(s) and ma stated.	nner stated
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		BV		30. Name and address of persor Fischatsion		ehar			1 23a) (1y) 1 0	M cdi	cal 1	Con	ter D	vive 1	Rock	-vIlle	Ma	2011 Yland:	20850
		Sta Registra		31. Date filed (Month, Day, Year) MAR 0 8 2011	6	32. [Registra	r's Signat	ture										
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07134 State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 201°1 D'Antoni Vincent A M 6:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1908 Knollton Rd. Timonium 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Hours 1 M 2 D F **Director** 2**16-**54-6692 60 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or or 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Timonium 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1908 Knollton Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ ☐ Yes 2**X** No f Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced SpecifiWhite Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Clerk Supermarket 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>John M. D'Antoni</u> Molly Houck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann W. D'Antoni/ Wife 1908 Knollton Rd. Timonium. MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Co. 3-14-11 Towson, MD. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licens 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr Yes 2 No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Besidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier WIDS MUSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincent Q. Wroblewski, Bellona tre Extremile, NO 21093 MED 1423 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year William J.C. Dulany, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 12310 Rosslare Ridge Rd. #407 Timonium 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 🗆 F Days Hours Director Maryland 86 <u>219-10-4246</u> Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD. Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12310 Rosslare Ridge Rd. #407 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other transmissions." ğ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mae Isabelle Jones William J.C. Dulany, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12310 Rosslare Ridge Rd. #407 Timonium, MD. 21093 Betty Lee Dulany/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Hilltop Service Co. Towson, MD 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROSTAR CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Day Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy prior to con death? 2 No Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Mannet of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 050760 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1407 HARles YORK Rd. STE 307 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

William

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH G913 3/11/2011 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 1SPM Month 3 Physician/ ALINA 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Adelphi Adelphi House 8. Date of Birth (Month, Day, Year) Jan 17, 1955 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 M Months Days Hours Washington DC Director 578-76-0667 56 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Maryland Prince George's Lanham 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number ò "natural", or items 23a or edical Examiner must be with 1 Funeral 20706 United States 9000 91st Place 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Health Care 4+ Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Page 1 and 2 should be iment of Health and Menta William W. Eldridge ,II Gladys Marie Tucker traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Melissa Eldridge-Scott/Sister 7107 Kurth Ln. Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 03/09/2011 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweel Onset and Death Immediate Cause (Final Physician/ IN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year ☐ Pregnant at time of death☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed After this certificate 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASS 13 Lead 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA LIVING FACULTY 27. Manner Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work s after death. 1 Tes 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date W T 20. Name and address use of death (Item 23a) (Type, Print) 445 DEFENSE HOW, ANDAPOLES, MD 2401 GHTFOOT-TAYLOR State MAR 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 10b,c,e,f per fh g914 4-8-11 yt
State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me,g913,03/30/2011dnb,23A,Ft1A
Certificate of Death
Regino Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 10.03 Am MILTON MACE ESTERSON MARCH 03 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURECARE CHERRYWOOD REISTERSTOWN nder 1 Year | If Under 24 BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 06/26/1918 1**X** M 2□F 92 218-05-9660 Yrs. Director MD Usual Residence of Decedent with the Maryland 10a State 10b. County St. Mary's 10c. City, Town or Location item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Mudical Examinat must be notified at 10d. Inside City Limits Charlotte Hall 1 ☐ Yes 2 👿 No PIKESVILLE Director 10e. Street and Number 29449 Charlotte Hall Rd. 10f. Zip Code 10g. Citizen of What Country? 20622 16 OLD COURT ROAD. #512 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Immortant: If tem 27 is marked other than "natural; or itema 23a any injury or other traumatic event. If a Wedical Examinar must. Once. 21208 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1XXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: þ WHITE Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 PROPRIETOR RETAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JACOB** ၉ **ESTERSON** ANNA MARCUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4839 DEER PARK ROAD, OWINGS MILLS, MD 21117
ace of Disposition (Name of Date 20c. Location - City or Town, State JOY WHITE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ANSHETEMUNATH CEM 03/06/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Subdural Hematoma Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner CERTIFICATION APPROVED BY MET CAT EXAMINER certificate be executed burial-transit attending physician and Due to (or as a consequence of) Box 68760 Physician/Medicai as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No to the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After th 28a. Date of Injury Found Day Year) 02/20/2011 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hatural 5 Pending investigation Probable multiple falls 2 Accident death. 1 Yes 2 XNo Unknown M Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Nursing Home 28! Location (Street and Number or Bural Boute Number, City or Town, State) Found: 29449 Charlotte Hall Rd., Charlotte filled in by 4 Homicide within 24 hours a 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Thermand MMVe 3/11 DA7683 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) Raymond Smith Avenue 2835 Miller Sunte 203 Baltrore 21209

DHMH 17 Rev 1/2001

State Registrar 31-Date filed (Month, Day, Year)
MAR 0 8 2011

Carke

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Firans Month 27 2:30 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Ratimore Health Kehab Overlea and 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 192 --476 Months Min. 248-34 Carolina **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c, City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☑ Yes 2 ☐ No laryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Madison Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ecify: Black ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 ₩Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Private Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha To Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Featherstone mie Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Annie B. Graham Benninghous 20a. Methed of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 M Burial 2 Cremation 3 Removal from State Mary Mak Lawn Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ Seasis disease or condition Medical resulting in death) as a consequence of): Examiner nonths de cubi tus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PVD, CKD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 **X** No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 completed filled in by the funera 1 X Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kaltimore, 40

V DHMH 17 Rev 7/2009

State Registrar Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Day AM **Physician** tfer. Datric 2011 Macch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) Oct. 4, 1 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ₹ M 2 □ F Maryland 53 Director 213-68-0623 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked and Injury or other traumatic event, the Medical Examiner must he marked the Injury or other traumatic event, the Medical Examiner must he marked the marked the Injury or other traumatic event, the Medical Examiner must he marked the marked 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1X Yes 2 ☐ No Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e, Street and Number USA 123 West Barre St. 21201 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 M Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Soc<u>ial Worker</u> 6+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Paul Fitzpatrick Marjorie Ann Lloyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joel E. Abrams / Partner 123 West Barre St., Baltimore, Maryland 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify)

21. Sign to e of Fineral Service Licensee Towson, Maryland Hilltop Service Corp 3-5-11 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 adons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) 18hour Due to or as a consequence of): Physician Medical 24 hours **Examiner** terial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner month Physician: The law requires that the death certificate be executed burial-transit hosis that initiated events and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) signed by the at 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \sum No has page 1 Yes 2 No 1 🗌 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Unpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury or Attending 1 🗌 Yes 2 🗌 No 2 Accident r death. 4 hours after death uneral Director: / filled in by the Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide City or Town, State) To the Hospital 24 hours a 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES -000 MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lov HERATI 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 11595

Registrar

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March Day 2011 2:00 P M Marilyn Estelle Flor Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 321 University Blvd W #232 Silver Spring . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Min July 9 New Jersey Months **Director** 1938 154-28-8499 72 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 United States 321 University Boulevard W #232 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates ortant, If item 27 is marked other than "natuinjury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marcel Auer Estelle Auer permit. Page 1 and 2 should be Department of Health and Mer Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 University Blvd. #232 Silver Spring, MD 20902 Lorein M. Flor / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 3/10/2011 Woodbine, Maryland Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician, Respiratory Failure disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year n signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? 2 🗌 No ☐ Yes 2X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c}\begin{arr 1 Tes 2 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?

Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate

the funeral director, after death Director: / filled in by

To the Hosp within 24 ho To the Fune completed f

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela M. Marshall 2101 Medical Park Dr. Suite 300E Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signaty State MAR 0 Registrar

5 Pending

Investigation

determined

6 Could not be

1 X Natural

Suicide

4 Homicide

29a. Certifier

(Check only one

Medical

Accident

3 🗌 29b. Signature and title of certifie iniury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea	-	•		nd / Dep		nt of H	lealth and	All Copie Mental Hy	giene	e on	ible.	0711.2	,
Physician		Registrar 1. Decedent's Nam		, Last)		al:a	CE	runca	le OI L	<u> eatri</u>	2. Date of De Month	D	ay	Year	3. Time of Death 6: 21 PM	<u>-</u>
Medica Examine		James 4a. Facility Name (iii Harb	f not institution,		et and numb	alin er)	-			Location of Deat	February		c. County	2011 of Death	1 0.277	
Funeral Director		5. Social Security N 216-78-6	lumber 844	6. Sex 1 X M		. Age (In yrs.	las <i>t birthday</i> ; Yrs.	_	er 1 Year	If Under 24 Hrs Hours Min.		th y, Year)	63	9. Birthp Coun	olace (State or Foreign try) Ohio	n
aryland a-f show fied at	Director	Usual Residence of 10a. State	Decedent 10b. County Baltin	oro			ty, Town or L							1	0d. Inside City Limits	
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hin 72 hou ne. than "natu ie Medical	Completed	Elementary/Sec		st grade c		or 5+)	(Give	DO NOT us	ork done d se retired)	ation luring most of wo	rking		Kind of Bu	·		
be filed wit ental Hygie rked other i ic event, th	as l	10 17. Father's Name (James Ca	(First, Middle, L	•			<u> </u>	Aspha	sphalt Road construc 18. Mother's Name (First, Middle, Maiden Surname) Oma Miller						struction	
nd 2 should ealth and M n 27 is ma ier trauma:		19a. Informant's Na Sara Fal			Print)		926	Impe	rial	Court, I	ural Route Numbe ansdowne					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a Method of Dis 1 Burial 2 4 Denation 21. Signature of Fu	Cremation 5 Other (S	pecify)	noval from S	tate 20b.	1) ~/ /	Crei	mator and Addres	y Mar.		Gle uner	n Bu	ome o	Maryland of Lansdow	'n
6 E E	dical Examiner	23a. art 1. Enter shock, or hea Immediate Cause disease or condition resulting in death) Sequentially list coif any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death)	onditions, nmediate	complicationly one call a. a. b c d. d	Due to (or	used the dea niline. Sma as a consequence as a consequen	uence of):			g, such as cardiac		rest,			Approximate Interval Between Onset and Death	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1										3d. Date of delivery Month Day Year				
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certifi rector	g Re	25. Was case referr examiner? 1 Yes 2	red to medical No	Hosp	oital:		1		Otho	ace of Death (Che					-	_
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ital or Atte		3 ☐ Suicide 4 ☐ Homicide	6 Could determ			f Injury - At h		treet, facto	ry, office		28f. Location (City or To			er or Rural	Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Medical	(Check 2	2 Medical E 3 Certifying	xaminer:	On the basis	of examination	on and/or inve	stigation, ir , death occ	n my opinic	n, death occurred time, date and pl	and due to the ca at the time, date ace, and due to th	and plac ne cause	e, and due (s) and ma	to the cau	use(s) and manner stat ated.	ed.
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21		30. Name and add	ess of person v	who comp	leted cause	of death (Iter	n 23a) (Type,	Print) 3	001	South	Hanover	- 5	tree	t	2011	
State		Abera 31. Date filed (Mont			32. F	istrar's Signa				timore	, MD 2	-12	25			
Registra			MAR 0	3 201	1 1	un	1. 1	backs	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death □2011 Physician/ March 4 12:43 A M Fritz Anna Virginia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 2711 Lawson Road Fallston Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day Year) 1906 Months Days Hours Min 1 M 2 XF Mary land Sept. Director 216-28-7575 104 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Harford Fallston Maryland ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21047 U.S.A. 27**11** Lawson Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married 2 X No Saltimore, Maryland 21215-0036 Yes within 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify "natural", Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Secretary Be ye 1 and 2 should be filed it of Health and Mental Hy If item 27 is marked ott 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Schinholtz Philomena Frederick Klingelhoefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 Fallston, Maryland 2711 Lawson Road C. Fritz Daughter Ponna 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o X Burial 2 Cremation 3 Removal from State 3-7-2011 John's Cemetery Hydes Maryland Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signatura Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2. No Pregnant at time of death 9 Unknown 9 Unknown cate has been signed by i page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 🔀 No after death.

Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 34208 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jarrettsville MD 3718 Day, State 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2011 3:30 Ам Joseph James Ferraro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Min. 1 XM 2 - F Days Hours March 18,1924 Italy 219-18-3481 86 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits r 28a-f shorn 10a. State 10b. County with the Maryland Director 1 ☐ Yes 2 🗓 No Westminster Maryland Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be r 21157 Funeral 2525 Bird View Rd. United States "natural", or items edical Examiner mu and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S Armed Forces Black, White, etc δ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) electrical foreman steel company Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ္ unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21157 Westminster, MD 2525 Bird View Rd. Anthony Ferraro/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XX Cremation 3 Removal from State Green Mount Crematory Mar. 4,2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland John O. Mitchell TV, Funeral Services of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 P. A. 21. Signature of Funeral Service Licensee 23a. Int 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached. Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: မ 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 🗶 Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 201 son who completed cause of death (Item 23a) (Type, Print) JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 Date filed (Month, Day, Year) State MAR 0 8 2011 Registrar

3,2011

FERRARO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 09:48 PM CHARLES MONROE FORD, SR. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MEMORIAL HOSPITAL Baltimore City N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 1 ₹ M 2 □ F Director 3-68-1084 July 16. 1956 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 1 Yes 2 □ No Maryland N/A Baltimore City 10e. Street and Number 10g. Citizen of What Country? Funeral 3345 Chestnut Avenue 21211 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 😾 Divorced Year or Dates ntal Hygiene. ed other than "naturs event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ Page 1 and 2 should be William Monroe Ford Elizabeth Mae Peacock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Monroe Ford, Jr. 329 Walgrove Road, Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Crematory 3/8/2011 Baltimore, Maryland 21. Signaturi of Forteral Aire is usee

Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Stroke disease or condition resulting in death) week Medical Due to (or as a consequence of): Examiner 4 ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Hospital or Attending Physician; 25. Was case referred to medica B 26. Place of Death (Check only one) 1 Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide 24 hours 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) AT 2438946 62 03.03.2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Majcl Al Ghatrit, MD 201 E. University E. University PKWY, Baltimore, MD 21218

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2<u>011</u> Month **Physician** ELEANOR JEAN BROWN FINNEY 5 March 12:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore

H Under 24 Hrs. KESWICK MULTICARE N/A 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Vear Hours Months Davs 1 □ M 2 😾 F 85 Oct 6, 1925 Maryland Director 220-12-1245 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it is redical Exp. in an institute routified at 1 ☐ Yes 2 😿 No Director Maryland Baltimore County Lutherville the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 502 Brightwood Club Drive 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 🔯 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry af Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be ပ Irving Frank Brown Mary Blanche Quimby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Clark Wharton Finney, M.D., 502 Brightwood Club Drive, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 3/8/2011 Baltimore, Maryland 21. Sign full of Functial S. Le lice issee

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final nysician a. ATHEROSCLEVETIC cerdioversion alrano disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performed certificate 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the tuneral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) o the within 2 To the and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO DO054056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 702 Belt MO 45 40 h

DHMH 17 Rev 1/2001

State Registrar 31. Date file (Month, Day,

ORIGINAL

MARCH 1, 2011 10:05 a.m. THELMA GOINS

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			For State Registrar		State of M	larylan		artment of <i>tificat</i> e <i>of</i>		and Mental Hy	/giene Reg. N	201		7147	
	Physicia	n/		ne (First, Middle, La	,					2. Date of D		ay_ Yea		. Time of Death	
, lang	Medi	cal		Elizabet				T		March	March 1, 2011 10:05				
-	Examir	ier	Stella		e street and number)	4b. City, Town, or Location of Death Timonium					4c. County of Death Baltimore				
	Funeral		Social Security N	lumber 6. S			st birthday)	If Under 1 Yea Months Days	If Under		8. Date of Birth 9. Birthplace (State or Fore				
	Director		214-26-4. Usual Residence o	DIZ f Decedent	□ M 2 🙀 F	87	Yrs.		Hours		4, 1	1923 West Virginia			
	nyland -f sho ied at	ctor	10a. State	10b. County		· '	, Town or Lo							Inside City Limits	
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	with the same same same same same same same sam	Funeral Director	3820 Ba	yville Ro	ad			21220				USA	Oodinity:		
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fun	11. Marital Status	ried 2 🗌 Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		l:	Nas Decedent of	oan, Mexican	gin? (Specify Yes or No , Puerto Rican, etc.)		14. Race - A Black, W Specify: W	hite, etc.	ndian,	
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Baltimore, Maryland 21215-0036	be filed w lental Hygi rked othe	To Be	17. Father's Name (18. Mothe	er's Name (First, Middle	, Maiden				
Mary	d 2 should be file alth and Mental H 127 is marked o r traumatic eve		19a. Informant's N	ame/Relationship (1	Type, Print) Daughter					er or Rural Route Numb					
more,	permit. Page 1 am Department of He Important: If iter any injury or othe once.				Removal from State	, ce		sition (Name of natory or other pla herd		Date 3/7/2011	1	ocation - City			
alti	ermit. F epartm porta ny inju		21. Signature of Fu			-	•			Sterling A					
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-	Physician/ Medical		shock, or hea Immediate Cause disease or condition resulting in death)	rt failure. List only o (Final	one cause on each line	e. TIVE	HEART	FATLURE	ng, such as	cardiac or respiratory a	rrest,		Inte	proximate erval Between set and Death	
	Examiner	her	Sequentially list co	onditions,	b. Due to (or as										
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. Box 68760	he death certificate be executed y the attending physician and ched for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnar	ncy			23d. Date of Month	delivery Day	Year	
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ita	sician: The certificate rector, pag	Be	25. Was case referrence examiner? 1 Yes 2		Hospital:				2011	h (Check only one)					
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Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 or	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined			me, farm, stre		i tes 2 🗆	28f. Location (City or To			Rural Rout	te Number,	
_	ne Hospit n 24 hour ne Funera pleted fille	Medical	(Check 2	Medical Exam	iner: On the basis of e	xamination	and/or investi	igation, in my opin	ion, death oc	place, and due to the ca	and place	, and due to th	ne cause(s)	and manner stated.	
	To the within to the complete		29b. Signature and	tige of certifier	2 CURACE	0		29c. Licen:	se number 497	192	29d. Da	te tigned (Mo	nth, Day, \	Year)	
	5V		30. Name and andr	ţ	completed cause of d	eath (Item :	23a) (Type, P	rint)			= = = = = = = = = = = = = = = = = = = =	111			
	Stat	e	31. Date filed (Mont		RNP 2300 32. Registra	ar's Sigmati	ire .	LLEY RD.	TIMO	NTIIM, MD 2	1093				
	Registra		MAR 08	2011	news > B.	pa	Ked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2<u>011</u> Month March 4, 2:10 P.M Mary Annette Granger 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 8205 Tyson Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 20, Months Davs Hours 1 □ M 2 🗷 F 215-09-8453 92 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 1 ☐ Yes 2 X No Augusta Staunton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Fairview Lane 24401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify: White Specify. 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Office Worker Clothng 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Callahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Granger Step Son 33 Fairview Lane; Staunton, VA 24401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 3/10/2011 Baltimore, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign ture of Funeral Service Lice

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

VA

Director

Funeral

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Completed

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Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: if item 27 is marked other tha any injury or other traumatic event, Ith. 1 and once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar cate has page 2 s

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

		- MANUEL V	11030	<u>tamonason Ave</u>	nue: Caton	sville.	MD 21228
	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the deat e cause on each line.					Approximate Interval Between Onset and Death
1	Immediate Cause (Final disease or condition	Failure	e to	mone			3 months
1	resulting in death)	Due to (or as a conseq	juence of):	West re-clien			
	Sequentially list conditions b.						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence of):			30	
5	that initiated events C.						
١	resulting in death) Last	Due to (or as a conseq	uence of):				
2	d						
	IF FEMALE:					1.1	
	23b. Was decedent pregnant in the past 12 menths?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	al death 3 Ectopic	pregnancy		23d. Date of del	livery Day Year
2	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of of 9 ☐ Unknown	death 5 ☐ Other (specify)		World	Du) 100.
	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	cause given in Part I	23e Did tohaco	n use contribute to	the cause of death?
2	Hypertens		diang in the disconying	cause giveri ii i air i.	1 □ Yes		robably 4 Unknown
3	179 00110115		1/ -		10103		
	Michelm	er Demon	trac		24a. Was an autopsy	/ prior to	utopsy findings available completion of cause of
5					performed 1 □ Yes 2 ☑		2 □No
3	25. Was case referred to medical examiner?				ath (Check only one)	/	Senior 1
2	TE Yes ZIAINO		ER/Outpatient 3 ☐ 0	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Spe	ocity) Resides
5	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
3	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		M	1 ☐ Yes 2 ☐ No			
	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factor fy)	ry, office	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
3							
3		sician: To the best of my kno ner: On the basis of examina					
	29b. Signature and title of certifier	and manner stated.	5	9c. License number	Mars L Dood	Date signed (Mont	th Day Year)
-	29b. Signature and the or certifier	2	ma		Mary buc 29d.	Morch "	
	KALOU CA	merces	CPIU	D 2523	7 /	Turch	1, 2011
	30. Name and address of person who con	mpleted cause of death (Item	Paris !	" Cotoni	Y/o Mo	rule. 1	2 01778
	-16 WONIN ICC	my well	Juile 20	7 -010150	1100	- Y CLECK	2100

Registrar DHMH 17 Rev 1/2001

State

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

32. Registrar's Signature

barke

31. Date filed (Month, Day, Year)

MAR 0 8 2011

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 2011 9:04 AM Ouidie J. Guerrieri Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dorchester Cambridge Chesapeake Woods Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Nov. I6, 1919 Months Hours Min 212-09-6803 91 PA Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29620 Porpoise Creek Road 21673 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 0.1 þ 1 Never Married 2XX Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 15, Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with... ⁴al Hygiene. `ar than "r∨ (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 11College (1-4 or 5+) the Dock Supervisor Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ Joseph Guerrieri Henrietta Ferri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mrs Joan Gunby / Daughter 29620 Porpoise Creek Road Trappe Maryland 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott March 11, 1 X Burial 2 Cremation 3 Removal from State Woodlawn, Maryland 4 Donation 5 Other (Specify) Lorraine Park Cemetery 2011 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Dementia Immediate Cause (Final Sevile Physician/ disease or condition resulting in death) Medical Cordio Vescular diteen Due to (or as a consequence of): Arteriusclemic Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death detached 9 Unknown P.O. ģ Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Records, 1 Yes 2 4 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy Yes 2 W No 1 Yes 2 4No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral Certificate: 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 29b. Signature and title of certifie 047924 3.7.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring BYRN ST CAMBRIDGE MD 21613 NOMAN THANWY 503 31. Date filed (Month, Day State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 03 2011 7:54 PM ROBERT GOLDSTEIN R Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours Min 0773171915 **Director** 95 MD 218-09-9620 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified · 28a-f 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be Funeral items 23a USA 6711 PARK HEIGHTS AVENUE, #301 21215 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ed other than "natural", or ite event, the Medical Examiner Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify If Yes, Give Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) FURNITURE STORE 12 MANAGER Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **ESTHER** SCHERR traumatic GOLDSTEIN and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Page 1 and 2: 6711 PARK HEIGHTS AVENUE, #301, BALTIMORE, MD 21215 LIBBY GOLDSTEIN/WIFE or other item Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PK. 03/06/2011 REISTERSTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ute musel Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is interested as or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be Records, 2 **N**o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death?
1 Yes 2 No perform certificate Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 M Other (Specify) NOSQ (2 M No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending death. Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

Charles ST TOWSON MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AHON J CHNUKS MD 6701 N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 1337 hrs March 1, 2011 Medical Examiner Willie Harris 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Sinai Hospital If Under 1 Year I If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex oreign Months Days Hours Min. Director 214-38-7007 75 Country) 1 M 2 F Yrs 7 GA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No show Baltimore NA within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4014 Norfolk Ave 21216 U.S.A. uneral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Yes è 屲 Black If Yes, Give Year 3 X Widowed 4 Divorced 1 Yes 2 No specify: Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th grade na Housewife Home of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) and 2 should be filed Be Ruben Faust Willie Huff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandra Jackson-Daughter Radecke Ave, Baltimore, Md 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, 1 Burial 2 Cremation 3 Removal from State crematory or other place) Garrison Forest Vet 3/9/201 Owings Mills, Donation 5 Other Specify 21. Signatule of Funeral Service Licensee 22 Name and Address of Facility
March F/H West
4300 Wabash Av Baltimore, <u>Ave</u> 23a. Part I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ıminer Due to (or as a consequence of) if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Exa events resulting in death) Last and hysician/Medical attending physician ior use as the burial -UNPENDED AMENDED of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the hed contributing to death but not resulting in the underlying cause given in Part I. <u>a</u> Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Mellitus Completed has been s 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? certificate Yes 2 ✔ No 1 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) examiner? Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Division 1 Yes 2 No Pending Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be within 24 hours a determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 2, 2011 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 08 Registrar

State of Maryland / Department of Health and Mental Hygien 👂 🥦 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** or Location of Death 4c. County of Death 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 215-66-1448 Months Days **Director** lune Usual Residence of Decedent or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No alti more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 monas 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file hand Mental H ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is Drown sosworth 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of F 20c. Location - City or Town, State cemetery, crematory or other place) ∃ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Mou Signature of Funeral Service Licensee Horus towel leights MD 2120 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or remiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last we to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 5 Other (specify) ☐ Yes ∠ ☐ ☐ Unknown the a signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 ☐ Unknown Completed 2 🗌 No plnous . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo ည 1 🗌 Yes Other: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work?
1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 28/11 606 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Mont State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fe bruan 11:13 p Medical Facility Name (if not institution, give street and number) Prince Georges Examiner 4b. City, Town, or Location of Death NIUSING-HOME 10 WIR Birthplac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Security Numbe 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💢 F Days Min. arolina Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No DIWIO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced ack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Sec anday (0-12) College (1-4 or 5+) obacco top Be 17. Father,'s Name (First, Middle, Last Mother's Name (First, Middle, Maiden Surname) ၉ HUNT formant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DON SOWIR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State INCO/N COH rent wood 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee un eral 2902 20794 10220 Koa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner 10222KS Sequentially list conditions il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c, Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, data and place and due to the 29b. Signature and title of certifier 29c. License number 00.514 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wood INT. Med Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 07^{Day} Mar Mvrrel C. Hendricks 20IT 11:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1440 Burton Avenue Lutherville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, ar 05, Months Days Hours 560-98-2354 **Director** 57 1954 California Mar Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Lutherville 1 Tes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1440 Burton Avenue 21093 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceuc... Armed Forces? ¹ ☐ Yes 2 【▼No 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Legal Lawyer 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Myrrel C. Hendricks, Sr. Smith Jean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allison Hendricks Wife 1440 Burton Avenue, Lutherville, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metro Crematory Inc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/08/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ months Medical Due to (or as a consequence of): resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy performed? Yes 2 No hin 24 hours after death.

the Funeral Director: After this certificate I

mpleted filled in by the funeral director, pag 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier A Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) · 12. D0059113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL 1650 ORLEANS ST.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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Barko

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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/ 	,	315 Chesterfield 5. Social Security Number 6. So				Centrev	7ille		r		Queen	_	
Funeral Director			M 2 🛛 F	e (In yrs. last bi	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da ()9/14)	th ay, Year) 1907	7	Count	ace (State or Foreign by) hington
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (T)				g Address (Street a				-		-	•
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Physician/		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line								U		Approximate Interval Between Onset and Death
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cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?						th (Check		2 III NO	1 10	103 2	
Physic this carral dire	욘	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 ☐ Inpatie 28a. Date of injur	nt 2 ER/O	utpatient Time of		4 ∟ N		me 5 🛭 Resid			pecify)	
nding ath. :: After e fune	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,		injury	28c. Injury work' M 1 🗆		.	8d. Describe h	now injury	occurred		
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined			arm, stree	et, factory, office		2	28f. Location (S City or Tow			Rural F	Route Number,
Hospital 4 hours Funeral ted filled	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examir	ician: To the best of n	ny knowledge, amination and/	death or	ocured at the time,	date and	place, and	due to the ca	use(s) and	d manner as	stated	se(s) and manner stated.
o the	ž	only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practioner: To the b	pest of my know	vledge, de	eath occurred at the	e time, date	and place	e, and due to th	e cause(s)) and manner e signed (Mo	as stat	ed.
F > F 0		2 nit	(Ves) dro	f m	1	DZ	577	42		•	3/4	1	1
		30. Name and address of person who co	ompleted cause of de	ath litem 23a)	(Type, Pri	int) md 2	161	7	EI	RIC	F.C	161	ANER MA
Stat	e	31. Date filed (Mohtlit, Day, Year)			-1-	, , ,							

DHMH 17 Rev 7/2009

State Registrar

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #25 per ME G916 6/28/11 TT State of Maryland / Department of Health and Mental Hygiene												
		ı	1 - For State Registrar	State of iviarylatio / i	Department of H Certificate of D		Hygiene Reg. No 1	07157					
	Physicia		1. Decedent's Name (First, Middle, Last)	11.110	l se.	2. Date o	f Death Day Year	3. Time of Death 4:47PM					
متنه	Medic Examin		4a, Facility Name (if not institution, give si			Location of Death	5 2011 4c. County of Deat						
- Line	Funeral		Union MEmoRia C 5. Social Security Number 6. Sex	Hospital 7. Age (In yrs. last birti		ORE If Under 24 Hrs. 8. Date o	NA 9 Rin	thplace (State or Foreign					
	Director		218-52-4109 12 Usual Residence of Decedent	MaDE 10	Yrs. Months Days	Hours Min. (Month	Day Year Co.	untry) / RYIANO					
	ryland I-f show ied at	Director	10a, State 10b. County	10c. City, Town				10d. Inside City Limits					
	hours after death with the Maryland natural", or items 23a or 28a-f sho lical Examiner must be notified at		10e. Street and Number	DAIH	10f. Zip Code		10g. Citizen of What Co	1 ✓ Yes 2 ☐ No ountry?					
	ns 23a must b	Funeral	6914 Old HAR	roed Road	2/23	/	USA						
စ္တ	fter dea , or iter	ρ	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No	If Yes, specify Cuban	spanic Origin? (Specify Yes or n, Mexican, Puerto Rican, etc.)	No- 14. Race - Ame Black, White						
9	nours at latural" ical Exe	eted	3 Widowed 4 Divorced 15. Decedent's Edu	If Yes, Give Year or Dates.	1 Yes 2 No		Specify:	Amelican					
21215-0036	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade	e completed)	(Give kind of work done du life. DO NOT use retired)	uring most of working	Flor L Can	Teansant					
	filed wi tal Hygie d other event, t	(t)	17. Father's Name (First, Middle, Last)	1/1/2	TRUCK D	18. Mother's Name (First, Mid	·	114111SPERT					
Maryland	ould be d Men marke matic	_	1911 TON Zugene 19a. Informant's Name/Relationship (Type	e. Print) 19h	Mailing Address (Street or	DORIS MARIE nd Number or Ryral Route Nui	Themas	Codel & Co.					
	1 and 2 sho if Health an item 27 is other trau		Josephine Hollar	nd-Spouse 69	21/21/1/	1 1 1 1 1 1	THIMOTE MAN	21234 24/And					
Baltimore	e : = 5	1	20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Removal from State	f Disposition (Name of ry, crematory or other place	/ i// /	20c. Location - City or	Town, State					
Saltir	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	GARR		of Facility WALLACE FUNE		s. MAKYMAND					
<u></u>	705 % Q	0. 73	23a. Par — Enter the disease, or compli	cations that caused the death. Do no	3405 W. F	RANKIN Street	-BAITIMORE						
	Trysician	X 0	shock, or head failure. List only one Immediate Cause (Final disease or condition	cause on each line. Massive (Large)	0 .	y Embolism		Approximate Interval Between Onset and Death					
	Medical Examiner		resulting in death)	Due to (or as a consequence o	of):	hemoraha		One day					
	d it	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due o (or as a consequence o	The second secon	116111011111	y C	1					
	executed ian and urial-transit		Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consequence o	of):	1 ASWLYS	COLL EXAMINED						
	ate be physicia the bur	edical	L d			TIFICATION APPROVED BY M							
687	eath certificate be attending physic for use as the bi	an/Me	zee: was accordent program	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death	2		23d. Date of del	ivery					
P.O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici eted filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year					
P.0	s that th gned by se detac	by Ph	Part II. Other significant conditions cont	ributing to death but not resulting in	n the underlying cause give	en in Part I. 23e. D	id tobacco use contribute to						
rds,	requires been sig	leted						robably 4 Unknown					
Division of Vital Records,	sician: The law certificate has t irector, page 2 s	Completed				р	utopsy prior to death?	topsy findings available completion of cause of					
ita :	sician: certifica rector, p	BG.	25. Was case referred to medical examiner? 1 X Yes 2 5 No.	ospital:	Othor	ce of Death (Check only one)							
of <	ng Physter this neral di	te: To	27. Manner of Death	1 Inpatient 2 ER/Out 28a. Date of injury (Month, Day, Year) 28b. Ti	tpatient 3 □ DOA	4 Nursing Home 5 R at 28d. Descrit	esidence 6 Other (Speci be how injury occurred	ify)					
sion	Attendir death. ctor: Af y the fu	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farr	M 1 □ Y	es 2 🗆 No	a Charact and Number of Du	ral Pauta Numbar					
DIX	ital or purs after ral Direction by led in by		4 ☐ Homicide determined	building, etc. (Specify)		City or	n (Street and Number or Rur Town, State)						
	To the Hospital or within 24 hours aft To the Funeral Discompleted filled in	Medical	(Check 2 \(\subseteq \text{Medical Examine} \)	ian: To the best of my knowledge, d r: On the basis of examination and/or Practioner: To the best of my knowle	investigation, in my opinion,	, death occurred at the time, da	te and place, and due to the o	cause(s) and manner stated.					
	To the within 2 To the complex		29b. Signature and title of certifier	0 1 000	29c. License r	number	29d. Date signed (Month	, Day, Year)					
	124	-	30. Name and eddress of person who com	npleted cause of death (Item 23a) (T	ype, Print)	38946(3 SPITAL B	3,5	, 2011					
	10 1		SAIRA BILAL 31. Date filed (Month Dev Year)	UNION ME	MURIAL HO	SPITAL P	altimore,	MD					
	State Registra	-	MAR 1 0 20	1 oz. m. grama s Signature	hav.								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pickersgill Towson If Under 1 If Under 24 Hrs. 8. Date of Birth 6 Sex 7. Age (In vrs. last birthday) Funeral Hours Months 1 □ M 2 F August 9. 214-24-3087 Yrs Director 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code Funeral 21204 615 Chestnut Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3x Widowed 4 □ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Beeler Anna Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Aspinwall (Daughter) 10 Wonderview Court Timonium. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corporation 3/8/2011 4 Donation 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ tu disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-t Physician/Medical Box 68760 signed by the attending p d be detached for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No Pregnant at time of death 1 Yes 2 9 | Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, cate has I To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2. No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d Date of delivery 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes 4 Narsing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3. Time of Death

10 55 AM

9. Birthplace (State or Foreign

White

10d. Inside City Limits

1 🗌 Yes 2 🙀 No

Maryland

Day

4c. County of Death

10g. Citizen of What Country?

USA

16b. Kind of Business Industry

At Home

Marvland 21093

Maryland

21204

Approximate Interval Between Onset and Death

20c. Location - City or Town, State

Towson

14. Race - American Indian,

Baltimore

State Registrar

only or 29b. Signatu

6701 31. Date filed (Month, Day, Year)

title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 9913 3-8-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 28. 20T1 9:20 A M Theresa Amelia Harward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Glade Valley Nursing Home Walkersville 8. Date of Birth
(Month, Day,
Jan. 9, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 926 Days New Jersey Min. 1 □ M 2 🔀 F Hours 85 **Director** 151-14-4772 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anotes. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 🔀 No Walkersville Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 56 W. Frederick Street 21793 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status was becedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ William (unk) Feustel Anna (unk) Assan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8921 Slabtown Rd., Hancock, MD 21750 Sandy Maillet / Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Air Memorial Gdn. 3-7-11 Bel Air, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility McComas Funeral Home, P.A. Kathlee Dantuasce 317 Cokesbury Rd., Abingdon, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line DEMENTIA Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death a Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 2 🗌 No 2 X No 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita Other: 2 🗷 No 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 \(\subseteq \text{Yes} \quad 2 \(\subseteq \text{No} \) injury Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature D0062223 2-28-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAYFEN BOLARUM, 196 TODLIVE, FREDENCE, MOLITO2 Name and address of person with a company of the AYEEN BOLARUM

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11 AM James Willard Helton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AIR Health Harton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** (Month, Day, 1 X M 2 □ F Hours Year Maryland Director 212-38-0124 71 Aug. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 54 Leona Drive 21918 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No Black White etc. or à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any rijury or other traumatic event, the Me any rijury or other traumatic event, the Me onee. Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Auto Repossession Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma Beulah Patrick Arthur Henry Helton Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3419 Walnut Road, Aberdeen, MD 21001 Margaret K. Boyle / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 3-8-11 Bel Air, Maryland 5 Dther (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Rd., Abingdon Sign ture 23a. Part 1. Enter the disease, or complications that aused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate rv Between and Death Immediate Cause (Final Physician/ W.USCL disease or condition resulting in death) Medical Due to (or as a contequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) Yes Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate 2 No Yes 2 1 L Yes To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? ပ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural 21 ^-5 \square Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only ene 29b. Signatur 29c. License number 9026 no completed cause of death (Item 23a) (Type, Print) Olvest 1308 Gususs Year) 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or Pri					_	•	э.	
		For State Registrar		State of M	arylan	·	artment of F tificate of L	Health and N Death	, ,	201	1 07161	
SI		1. Decedent's Name					incate of E		2. Date of Deat	_	3. Time of Death	
Physicia Medic	al	James		•					March 1,	2011 Year	7:50 P. ^M	
Examin	er	900 Swallo	ow Crest (ourt Unit C			Edge	Location of Death		4c. County of De Harford		
Funeral Director		5. Social Security Number 218-72-8623 Usual Residence of Decedent 6. Sex 1 XC M 2 G F 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 9. E Months Days Hours Min. 1 Win. 1 Win. 1 No. Days Hours Min. 1 No. Min. 1 No. Days Hours Min. 2 No. Days Hours Min. 2 No. Days Hours Min. 2 No. Days Hours Min. 3 No. Days Hours Min. 3 No. Days Hours Min. 4 No. Days Hours Min. 5 No. Days Hours Min. 6 No. Days Hours Min. 6 No. Days Hours Min. 7 No. Days Hours Min. 8 No. Days										
land show dat	tor	10a. State	10b. County		10c. City	y, Town or Loc	eation				10d. Inside City Limits	
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s 23a c s ust be	eral	900 Swallow		ourt Unit C			21040)		10g. Citizen of What (country?	
r death or item niner m		11. Marital Status 1 🗶 Never Marri	ied 2 Morrie	12. Was Decedent I Armed Forces?			Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	,	
urs afte ural", c	ted by	3 Widowed	4 Divorced	If Yes, Give Year or Dates.	, NO	1	☐ Yes 2 🔀 No	Specify:		Specify:	hite	
72 hou in "nat Medica	Completed			grade completed)		(Give k	NOT use retired)	during most of worki	ing	16b. Kind of Busines	s Industry	
d within ygiene. her tha nt, the I		Elementary/\$200		College (1-4 or s	5+)	Sale	es Represer			Commercial	Rentals	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (F Stephen M.	Hollie,S	ŕ.		1		18. Mother's Name Catheri	ine A. Jan	Maiden Surname) I SEN		
nd 2 shouealth and m 27 is mer traum			M. Holli	e, Sr Fathe	er			and Number or Rura st Court U		City or Town, State, 2 gewood, Mary		
Page 1 a nent of H ant: If ite ary or oth		20a. Method of Disp 1 Burial 2 4 Donation		Removal from State	C	emetery, crem	sition (Name of natory or other place	e) 03 – 07	-2011	20c. Location - City of Towson Mary		
permit. Departitimport		21. Signature of Fur	neral Service Lic	ensee			Name and Addres	s of Facility RUCK, Inc.	5305 Balti	Harford Road more Marylar		
		shock, or hear	rt failure. List onl	omplications that caused y one cause on each line	the death	n. Do not ente	r the mode of dying	g, such as cardiac c	r respiratory arre	st,	Approximate Interval Between	
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9 1 9	ᇹᅵ	resulting in death) L		Due to (or as	a consequ	ence of):						
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e Hospita 124 hours e Funera eleted fille	Medical	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or investig	gation, in my opinio	n, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.	
To th withir To th		29b. Signature and t	title of certifier	DIRECT MEDICA	TUR,		29c. License	number	25	9d. Date signed (Mon	th, Day, Year)	
101											21287	
Stat Registra	е	31 Date filed (Month)	7, Day, Year) R 0 8 201	22 Pagietre	ar's Signatu	Je Spark	4	, (·	•	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9913 3-15-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) David Charles Hennel Jr. 2. Date of Death Physician/ Year 15 AM Meirch 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saltimore Baltimore Medical Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. Oct. 17, 1944 Maryland Director 212-44-1719 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3302 O'Donnell Street 21224 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Divorced 4 Divorced White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Years Boilermaker Local 193 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David C. Hennel, Sr. Margaret A. McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3302 O'Donnell Street Baltimore, Maryland Mrs. Theresa Hennel (Wife) 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 3/7/2011 Dundalk, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7022 Wise Ave. Dundalk, Maryland 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year 2 🗌 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 💢 Probably 4 🗀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 🗌 Yes 2 🔽 Be completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Tes 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my physician death occurred at the time, date and place, and due to the cause(s). (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number NPI #: 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul J 301 St. Place Lennon ک 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 08 Registrar

			For State Registrar		State o	ıwaryı		partment of t ertificate of		vientai my	/giene Reg. No		07:00
			1. Decedent's Name	e (First, Middle, La						2. Date of D	eath Da	ay Year	3. Time of Death
	Physici /Medio				Gail		Lynn	Harvey	<u> </u>	3	3		430 PM
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7	<i>"</i>		FRANKLIL 5. Social Security N				yrs. last birthd		s eda (e.	O Data of Bi	irth	BaLTI	
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	and		Usual Residence of 10a. State	10b. County		10c	. City, Town or	Location				1	10d. Inside City Limits
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	or 282	Jirec	10e. Street and Nur	nber				10f. Zip Code			10g. Ci	tizen of What Cou	intry?
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2 Z	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name	d W. Sand					18. Mother's Nam		e, Maider	n Surname)	
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Division of Vital Records.	tal or A rs after al Direc	Certification:	4 Homicide	determined	buildi	ng, etc. (Sp	pecify)	street, factory, office		City or To			a noute number,
	To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	12 Certifying Ph 2 Medical Exar	niner: On the b	best of my asis of examer stated.	knowledge, d mination and/c	eath occurred at the t r investigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time	e cause(e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	To the Hospital or Attending Physician: The law requires that the death certificate be executed	Division of Vital Records, P.O. Box 68760
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg No 2 1 1 1 7 1 5 1												
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		GILCHRIST HOSE	PICE				WSON			BALTIM	ORE	
Funeral		5. Social Security Number 249–34–4835	6. Sex 7. Ag 1 ★ M 2 ☐ F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	r 24 Hrs. 8. Date Min. (Mon			irthplace (State or Foreign ountry)	
Director		Usual Residence of Decedent		84	113.			APKI	.L 1/	,1920	30	
land Fshow dat	tor	10a. State 10b. County		10c. City	y, Town or Loc	cation					10d. Inside City Limits	
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ith the	ral	10e. Street and Number				10f. Zip Code	200		10g	g. Citizen of What C	Country?	
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Page 1:		1 XBurial 2 Cremation		C		natory`or other plac	сө)	Date 03/12/201		c. Location - City of ALTIMORE		
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tth cel	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	I death 3	Ectopic pregnand Other (specify)	cy /	Si.	\	23d. Date of o	lelivery Day Year	
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical I		xamination	and/or invest	tigation, in my opinio	on, death o	ccurred at the time,	date and p	lace, and due to the	e cause(s) and manner stated.	
ithin 2 o the		only one) 3 Certifying 29b. Signature and title of certifie	Nurse Practioner: To the	best of my	r knowledge, c	death occurred at the		e and place, and due		use(s) and manner a . Date signed (Mor		
FSFŏ		> 1 chat	M	D			1040	5	230	3/6	11	
/		30. Name and address of person	who completed cause of d	leath (Item	23a) (Type, P		4.	_		1 9	1	
5		ARATHI KUMAR		CHAR		St Sunt	12 4I	105 BA	LTIM	ORE MD	21204	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 23a per dr., g913,03/08/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wen An Hu Physician/ Month Day 2011 10:00am^M February Medical 4c. County of Death
Montgomery 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Suburban Hospital Bethesda Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days 03/07/1915 95 1 🔀 M 2 🗆 F 096-64-0258 **Director** Yrs. China Usual Residence of Decedent f show ould be filed within 72 hours after death with the Maryland to Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10b, County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Bethesda MD Montgomery 1X Yes 2 ☐ No 10e. Street and Number 10g, Citizen of What Country? Funeral China 5225 20814 Pooks Hill Road, Apt. 1509N 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 Asian Specify: 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemistry Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) $Y \bullet T \bullet \text{ Chen}$ Y. K. Woo permit. Page 1 and 2 should Department of Health and M Important: If item 27 is ma any injury or other traumat once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8923 Falls Farm Dr., Potomac, MD 20854 Dao Hu / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 2/28/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshal 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD21 203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of) Examiner Hypernatremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). Aspiration Pneumonia that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of). Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 **X**No Other: ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 \square No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

10:00 am 2011 Box 68760 DYMAY 26, P.O. Records, the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific mpleted filled in by the funeral director, 2 Division of Vital Men JAHA! within 24 hours a
To the Funeral I
completed filled

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State Registrar

Medical

29a, Certifier (Check

29b. Signature and title

certifier

Gertifying Nurse Practioner: To the best of my knowledge

Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

02126/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per doc g913 3-8-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Celeine M. Hartung March 2011 2:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 204 Eastridge Garth Baltimore Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Y June 29 **Funeral** 9. Birthplace (State or Foreign 1 M 2 X Days Hours Min Months Country Director 213-32-4096 75 Yrs 1935 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Timonium 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12101 Tullamore Ct. Condo 103 21093 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😿 No Specify: 3 X Widowed 4 Divorced Completed Specify white and Mental Hygiene.
s marked other than "natural turnal the Medical Example of the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Business Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Shramek Garaldine Schott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Worsham/Daughter 204 Eastridge Garth Rd., Timonium, MD 21093 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Louden Park Cem. 3/8/11 Balto., MD Signature of Funer 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley, O W. Padonia Rd., Timonium, MD 21093 Inc. Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 0/0N Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes 2 🗌 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one daughter's 2**64** No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 6 X Other (Specify) home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Director n 24 hou.. **the Funeral Dire**.. مط filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Paul Celano **GBMC** 6569 N. Charles St., Suite 205, Towson, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

MAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 27, 2011 Physician Catherine A. Harman 2:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pickersgill Nursing Home **BAltimore** Towson Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√F Months Days Hours Director 216-07-1149 97 Aug 19,1913 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nother many injury or other forms." 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2√√No Funeral Director MDBaltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue U.S.A. 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Wo If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2XXXNo Completed by Specify: Specify: 3 Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Hutzlers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William G. Chenowith Mary Edwards ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William R. Harman (Son) 8 Pickburn Ct. Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Description | 2 □ Cremation | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) Lorraine Park Cemetery Woodlawn, MD 3/3/11 22. Name and Address of Facility
Burgee Henss-Seitz Funeral Home,
3631 Falls Road Balto, MD 21211 21_8ignature of Euneral Service License 23a. Part 1. Let the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician REBROUNSCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Completed by Physician/Medical Examiner Directo (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mont Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, TYPEZ DIABOTES MPLLITU 2 No 3 Probably 4 Unknown CURONARY ARTER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEMENTIA 2 No 1 ☐ Yes 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicían: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) OPTH CHARLES STREET BALTIMURE MD21204

Registrar DHMH 17 Rev 1/2001

State

11 CHAEL

31. Date filed (Month, Day, Year)

MAR 0 8 2011

NKROM MD 6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens			Ro Ro	beri				unera <u>l</u>				le, Inc. yland 208	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical **Examiner** ition, give 7. Age (In vrs **Funeral** st birthday 8. Date of Birth Birthplace (State or Foreign Country) Min Director or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State death with the Maryland Completed by Funeral Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be once. 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. College (1-4 or 5+) Health and Mental Hygiene. Be Name (First, Middle, Last) ည Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licenses 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated expects) Examine Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be O. Box 68760 use as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ó Day Year page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PEGGY Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perforn 1 Yes 2 No Yes funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ဂ 1 🗀 Yes Other: 1 Inpatient 2 within 24 hours after death.

To the Funeral Director: After this ER/Outpatient 3 DOA 4

Nursing Home Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident 2 No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and time 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 1:40 A M Heper Eleni Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Carroll County General Hospital Westminster Carroll Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral July 1917 1 🗆 M 2 🔀 F Days Hours 93 Director 213-68-0390 Türkey Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits or 28a-f 1 Yes 2 XNo Maryland Carroll Finksburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral items 23a 3153 Slasmans Road 21048 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. "natural", or 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 27 is marked other than "natur traumatic event, the Medical 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Petros Mavrommatis Mavrommatis Smaro f Health an. m 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tony Heper / Son Slasmans Road Finksburg, Maryland 21048 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Demetrios Cemetery 3/9/2011 Cub Hill. Maryland Signature of Fundamental Ce Lice 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🖳 N Yes Be (Hospital or Attending Physician: 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Hospital ဂ္ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work To the Hospital or Attendii within 24 hours after death. To the Funeral Director, Al 1 🗆 Yes 2 🔲 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Business MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Arthur L. Hannon 201 5:55A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SINAI MOSPITAL OF BALTIMORE BALTIMORE CITY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y Hours Min. Pennsylvania 84 Director 200-16-2009 Usual Residence of Decedent er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland 10c City Town or Location **Funeral Director** 10d. Inside City Limits 1 √ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 219 Edgevale Road 21210 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? e filed within 72 hours after data Hygiene. ed other than "natural", or i Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates 3 Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Steel Industry Accountant permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic event, once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Arthur Hannon Maryclare O'Malley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John McCauley 219 Edgevale Road; Baltimore, MD 21210 nephew 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Hilltop Service Corp. 3/8/2011 Towson, MD 21. Signature of Funeral 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death h, sician/ PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ISCHEMIC CARDIOMYDPATHY Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or se a consequence of). CONGESTIVE HEART FAILURE Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🔲 Yes 2 XNo Other: မ 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MAR 6, 2011 D0061959 e and address of person who completed cause of death (Item 23a) (Type, Print) OF BALTIMORE M.D SINAL AMAN SIBM MOSPITAL 31. Date filed (Month, Day, Year) 32. Registra s Signature State MAR 08 2011 Registrar

DHMH 17 Rev 7/2009

ARLIOS

TANNON

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March ୦୯∵ଅ୬_{୫ ୴} 5011 ANDREW LEE HOWELL 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Agnes Hospital altimore
1 Year | If Under 24 Hrs. N/A Social Security Number Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Months Yrs. Director 226-20-0980 87 4-21-1923 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Directo N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 21229 23 N. MONASTERY AVE, USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☑ No Specify. ð Specify: BLACK 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN BALTO, CITY SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES HOWELL VINNIE BASKERVILLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a YOLANDA REED (DAUGHTER) 1266 BOONE HALL DR. POWDERSPRINGS, GEORGIA 30127 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Pages 1
Department of H
Important: If ite
any injury or ott 14 Burial & □ Crematiøn 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 3-11-2011 LAUREL, MARYLAND 21. Signature of Fundal Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Pa 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.

Immediat 20 use (Final disease or condition resulting in death)

a. Due to (or set concerned of the concerned o Approximate Interval Between Onset and Death Physician Days /Medical Due to (or as consequence of): Examiner Urinary tract Intection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Sacral wound infection
Due to (or as a consequence of): CETTIFICATION APPROVED BY MEDICAL Days to Week, ending physician and use as the burial-tran attending p Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a e detached for 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Respiratory 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown lalnutrition 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 autopsy perform 1 □ Yes of Vital Hospital or Altending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes ZONO 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred o 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Divisi 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Avenue Baltimore, MD 21227 Juma Shannarose 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 24iXWAH 4:50 PM MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIHORE - WASHINGT<u>O N HEDICAL CENTE</u> CLEH IBOHIMA HUA BURNIE . Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Sept. 26,1954 1 □ M 2 🔀 Days Hours 214-62-1305 56 Maryland Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Forest Street 21061 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates uth and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Pharmacuticals Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde Russell Eye Shirley Sowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest St., Glen Burnie, Maryland 21061 Edward W. Hawkins / Husband item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 10, Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 X surial 2 Cremation 3 Removal from State Elkridge, Maryland Meadowridge Mem. Park 4 Donation 5 Other (Specify) F vne al Ser kley-Ruddick Crain Hwy., Funeral Home, P.A. SE, Glen Burnie, MD 21061 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CHRONIC OBSTRUCTIVE PULHONARY DISEASE 2AA3YOI disease or condition Medical resulting in death) Examiner 304EARS SHOKING Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 2 **X** No should be detached 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No prior to completion of cause of death? page 2 1 Yes 2 No 24 hours after death.
Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 🔀 No Other: မ 1 🗌 Yes 1 Nation 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hou To the Fune completed fi 29b. Signature and title of certifier Di Odme José Gwipper, HO D006571A WWBCH 27 5011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUILLERMO JOSE GIANGRECO BOI HOSPITAL DRIVE, GLEN BURNIE, MD 2016 31. Date filed (Month, Day, Year) State MAR 08 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2011 BRUARYZ Allan Jackson, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number | 6. Sex | 17 Ang / in was 15. 3ALTIMO 8. Date of Birth (Month, Day, Year) 02-24-1942 If Under 1 Year If Under 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min New York **Director** 100-32-1529 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mential Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Iry or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 446 Elmhurst Street 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sanitation City Government 12 TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Jackson ဥ Harriet Sampson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan Jackson, Jr. (Son) 148 Belknap Avenue Yonkers, New York 10710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department o Important: If Ferncliff Crematory 4 ☐ Donation 5 ☐ Other (Specify) 3-5-2011 Hartsdale, New York 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Baltimore, MD 21224 6224 Eastern Avenue and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SERSINS /Medical Due to (or as a consequence of): Examiner RIWARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

✓ es 2 □ No 24a. Was an certificate has autopsy performed 2□ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Dea 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only within 24 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

900 CATON AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KREY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JERSON Physician/ VEWPORT Month 0 1:30 A M Feb. 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery Montgomery General Hospital Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Mar 7, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** Months Days 1 □ M 2 🛛 F **Director** 1931 79 Hawai 578-42-3118 show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f shw 10a, State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 USA 610 Greenbrier Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilfred Lawson Butt, Jr. Beatrice Linsley Newport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box 192 Friendsville, MD 21531 Walter R. Jepson/son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it Page 1 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crematory 03/05/11 4 Donation 5 Other (Specify) Woodbine, MD Going Home Cremation Service P.O. Box 784 21. Signatur of Funeral Service License Beverly L. Heckrotte, P.A. Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ELECTRICAL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner ARDIO NASCULAR DISEASE been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? GASTROINTESTINAL BLEEDING 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed eral Director: After this certificate filled in by the funeral director, pag 2 🗌 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} Hospital Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direct 29a. Certifier 1 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date şigned (Month, Day, Year) 30. Name and address of Person who completed cause of death (Item 23a) (Type, Print) 10605 CONCORD ST KENSINGTON, MD

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.? Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Roland Keno Kent III **Physician** 0 /Medical Town, or Location of Death 4c. County of Death (If not institution, give street and number) **Examiner** 8. Date of Birth (Month, Day, 01 17 9. Birthplace (State or Foreign Social Security Number **Funeral** Year) Months Davs Hours Min. 1 XM 2 ☐ F 01 54 Director 57 MD 214-64-8728 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It whe dies in a result to mother than the contract to the contract of the contract to the co 1√ Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 2439 Keyworth Ave U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Justice 12th grade Maintenance na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anita White Roland Keno Kent I မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 SMount Street, Baltimore, Md 21223 Roland Keno Kent III-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3/3/2011 Baltimore, Md 4 Donation 5 Dother (Specify) On-Site 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Par 1. Enter the direase, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart helicities. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ficate has been się r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Division of Vital 1 □ Yes 2 PNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭2No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 124 hours after death.

12 Funeral Director: Appletely filled in by the fi investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 000 M,D30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD 21287 Voun G KHINH (III) 31. Date filed (Month, Day, Year) 32. State racket Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 3 KOKKINOS CINNAO 5:59 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore 6. Sex 1 ፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 0ct. 18, 1927 216-88-5950 Greece Director 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or itemated or other trainments. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City N/A MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 414 Hornel Street Greece Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Completed by 1 Never Married 2 X Married 1 Yes : 2 X No 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 6 Years College (1-4 or 5+) Shoe Making Industry Shoemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Eugenia Phillipou Emmanuel Kokkinos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Hornel Street Baltimore, Maryland 21224 414 Hornel Street Anna I. Kokkinos (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimore, Maryland 3/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland art 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure that only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Yneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ondenying Cause (Disease or linjury Examiner Due to (or as a consequence of To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown plnous eral Director; After this certificate has been filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 1 No Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 6 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MARCH 201 Î 03. KARASIK 8:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6938 MARSUE DRIVE, BALTIMORE N/A Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) BELARUS 6. Sex 7. Age (In yrs. last birthdav) 8 Date of Birth Funeral 1 □ M 2 🛣 F Days Hours Min 0672571934 **Director** 220-33-4194 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No MD BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6938 MARSUE DRIVE, 21215 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 X Married ò 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. WHITE Specify. 3 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 should be MONTATSKIY LEA CHERNYAK permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ABRAM KARASIK/HUSBAND 6938 MARSUE DRIVE, 1B , BALTIMORE, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. D3/06/2011 REISTERSTOWN. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death rebra Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 Yes 2 No Yes 2 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 200 Other: ٩ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending s after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number D0054746 03/04/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEXANDER POKOV, M.D., 6821 REISTERSTOWN ROAD, SUITE 206, BALTIMORE, MD 21215 31. Date filed (Month, Day, Year) 32. Registrar' Signatur MAR 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RGARET MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **Baltimore** Pickersgil1 Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🕇 F Days Ap/ 17 th, 10 Ye1 923 Min. 219-10-0592 87 MaryTand **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 28a-f Mary land Baltimore Towson 1 ☐ Yes 2 🛚 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 21204 U.S.A. 615 Chestnut Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Nidowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o Lenore Kahoe Christian Volz and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alta, California item 27 Nancy Kaufman / Daughter P.O. Box 697 95701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Druid Ridge Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 3/9/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OR OBROVASCULAR Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to for es e pansacianos oficause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mo Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by HYPERTENSION Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes METASTATIC BREAST CANCER 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2011 Physician/ March 6 4:15 A M ROSEMARY BUZZA KLEIN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timonium Baltimore County STELLA MARIS HOSPICE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, 1 □ M 2 💢 F Months Days Hours Min **Director** 187-20-2901 Pennsylvania 83 Aire Usual Residence of Decedent or 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Maryland | Baltimore County Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 2525 Pot Spring Road, L-320 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black. White, etc "natural", or ģ 1 Never Married 2 X Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea ones. Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Corp. Secretarial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert J. Buzza Norine Crowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Walter H. Klein (Husband) 2525 Pot Spring Road, L320, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 3/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdn's Timonium, Maryland 21. Sign vy Fuyeral S Cells

Martin D. Lav Lawson MITCHELL WIEDEFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a 1 Yes 2 4 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy performed? Yes 2 N 2 🗆 No 1 Yes Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 ☐ Yes 2 X No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 X Natural 5 Pending work Accident 1 Tes 2 🗆 No Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

KLEIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mar. O Pay Celicia Ann Lydard 20**T** 5:03 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Catonsville Baltimore 107 Ingleside Avenue Social Security Number 8. Date of Birth De Month, Pay, Year 32 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Country)Maryland 1 M 2 XF 217-28-5986 Director 78 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sinjury or other traumatic event, the Medical Examiner must be notified. Maryland Baltimore Catonsville 1 ☐ Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Ingleside Avenue 21228 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 2 🔀 No 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Little Sisters Of Elementary/Seconday (0-12) College (1-4 or 5+) Dietitian The Poor 8 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John W. Edith Bell Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Mitchell / Daughter 107 Ingleside Avenue, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Metro Crematory Inc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/07/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8 Menths Immediate Cause (Final Physician/ Small disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to (or all a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 m hths?
1 Yes 2 No Dav Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tyes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 No Other: ၉ 1 🗌 Yes ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 M Residence 6 ☐ Other (Specify) 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **▼** Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of ce who completed cause of death (Item 23a) (Type, Print) aton

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State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 March 3, 0542 Irene Μ Luczai Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 24, 1914 Massachusetts **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours Min. Director 042-01-2025 96 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Hartford Enfield 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Avon Street 06082 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emery Chaput Mary Morrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise McHugh (Daughter) 8620 Garfield St., Bethesda, MD 20817 20a. Method of Disposition
1

Barial 2 Cremation 3

Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Leerenstrevenshield 3/8/2011 4 ☐ Donation 5 ☐ Other (Specify) Enfield, CT Chapels & Crematory Signature of Funeral Service Licen x e 22. Name and Address of Facility Leete-Stevens Enfield Chapels & 61 South Rd., Enfield, CT 06083 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarct disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed Congestive Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 K ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D54336 March 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, MD 20814 Michael Londner, M.D. 31. Date filed (Month, Day, Year)
NAR 0 8 2011 State Registrar

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Za!

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #7perFH. G913.3/9/2011 WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LIAM Physician/ Month 201 220 FEB Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard County General Hospital Howard Columbia Social Security Numbe Sex 1 🖾 🔏 2 🗆 F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Feb 6, 1922 Country) Director 191-14-3758 89 PAUsual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1XXYes 2 □ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral U.S.A. 20708 9314 Player Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Black, White, etc. African Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XXIo Specify: If Yes, Give Completed 3 X Widowed 4 □ Divorced WWII American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Years Elementary/Seconday (0-12) Hospital Administrator Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pearl Hicks William Lafayette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20708 Janine Lafayette granddaughter 9314 Player Drive Laurel, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🖾 remation 3 ☐ Removal from State 4 Donation 5 Other (Specify) W. Arundel Crematory 3/5/2011 Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 20707 23a, Part 1. Enter the disease, or co mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only ne cause on each line Immediate Cause (Final BLEEDING **Enysician** disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PANCYTOFNIA Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or iinjury Dust to (or #8.0 donariquinari of) MYELO PYSPLASTIC attending physician and for use as the burial-transit SYNDROME Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown should VASCULAR DEMENTIA 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has funeral director, page 2: autopsy performed PROSTATE After this certificate CANCER 2 No 2 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Acciden
3 Suicide injury 5 Pending Work? 1 ☐ Yes 2 ☐ No Accident Investigation Director; the Funeral Dire. 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. прleted (Check within 2 To the F 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) Cemo DO043662 12011 28 FEB 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Willham BoyLEJ County Hosp 31. Date filed (Month, ay, Year) State MAR 08 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10g, 18 per fh g913 3-8-11 vt
State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month O2 13:10 M 28 2011 Matt Ariana AKA Mohommad Reza Mozzaffari Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Sameritan Haspital BranHlersT If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 05 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 XM 2 □ F 212-41-0065 Director Iran 41 Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 X No MD Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō the 27 is marked other than "natural", or items 23a of other traumatic event, the Medical Examiner must be Funeral Iran 8104 Ridgetown Drive Apt J 21236 U.S.A permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Unemployed Unemployed na Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Hajiali Khani Hajazikhani မ Ebrahim Mozzaffair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Michael Arasteh-Friend P.O. Box 818, Sparks, Maryland 21152 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 3/4/2011 King Woodlawn, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Sig of Funeral Service Licenses Baltimore, Md 23a. Partil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Heart Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death , verous Ph_sician/ Medical Examiner redon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atte page 2 should be detached for in the past 12 months? Month Dav Year 1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate h 2 110 ☑Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner2 Hospital: Other: 2 🗆 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Des 000 28/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 5601 Loch Raven Blud Mohan Rudrappo, 21239

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 8 201

32

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 Month James Peter McAleer A M March 2:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign July 24, Year) 930 1 ፟ M 2 □ Days New York Director 087-22-6039 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 🗌 Yes 2 🏝 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 10620 Tulip Lane 20854 United States Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 X Married 1 X Yes 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White Completed 3 Divorced 4 Divorced Year or Dates. 1953-1955 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Legal Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John McAleer Mary Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian J. McAleer / Wife 10620 Tulip Lane Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Marchate5, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 2011 Baltimore, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home Rockville, Inc.
300 W. Montgomery Avenue Rockville, Maryland 20850 21. Signature of Fundral Service Lice M01607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Alzheimers Dementia vears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗓 No Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 2 🛛 No Other: ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 🔀 Natural 5 Pending Accident 1 Tes 2 No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 3-3-2011 ess of person who complete ed cause of leath (Item 23a) (Type, Print) Geoffrey Coleman, M.D. 1355 Piccard Drive Rockville, Maryland 20850

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Murray Physician/ Month Bayth 2011 amuel 10:17 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hmol 170 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 🗆 M 2 🗆 F 223-40-84 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director Himore 1 ¥Yes 2 ☐ No MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral OV WOOD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. or. Completed by 1 Never Married 2 Married 2 🗌 No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Army 3 🗆 Widowed 4 🗆 Divorced "natural", traumatic event, the Medical 6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) river Iranspor noitot Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e 19a. Korpani's Name/Belationshim Type Paint 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 101 mood 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ido 22. Name and Address of Facility towell 4600 Hima 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as contract liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death END Stage Physician/ inal Isease disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sease organ if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ę Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown been signed by the should be detached 9 Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cerebro Vascular accident Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown arthrial 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed' this certificate Yes 2 No 2 No 1 🗌 Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes Other: 2 No ၉ 1 K Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Director 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Fune al Direct determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Strippertifying Nurse Practioner. To the best of my knowledge, Seath consumd at the time date and plans, and due to the or 29b. Signature and title of dertifi 29c. License number 29d. Date signed (Month, Day, Year) 6th, 2011 March 1)45148 Medical s of person who completed cause of death (Item 23a) (Type, Print) , Baltimore, Maryland 2000 West Baltimore Street Ni cicardo Usorno 21723 ate filed (Month, Day, Year) 32_Registrar's Signature State Registrar N o 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Murray 2011 Medical 4a. Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lowson altimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Month, Day, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🖼 Country) Director Yrs. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Nes 2 No tima 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Be 1 and 2 should be filed of Health and Mental Hy 17. Father's Name (First, Middle, Last) Unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, <u>Cit</u>y or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Himore ames vinadale MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Termation 3 Removal from State altimore 5 Other (Specify) MD 4 Donation Signature of Funeral Service Lices 22. Name and Address of Facility oweld meral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ liver + ovanies Neuplusm of disease or condition Year S Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No ρ Pregnant at time of death 2 should be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has , page 2 No 1 Yes or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner's Hospital 2 1 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Comer (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or number within 24 hours after death.

To the Funeral Director: After the Funeral Director After To the Funeral filled in by the fur Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Entifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0070635 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4106 Baltmore, 40 zizing Svite Pa 6701 Charles St 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Funer Direct

	1	State Registrar		Certifi	cate of L	Death	1	Reg. No	2011	0710
an/		. Decedent's Name (First, Middle, Last)					Date of Dea Month		y Year	3. Time of Death
cal	_	Betty Ann Myers					March	7,	2011 Year	10:15 P.
ner		a. Facility Name (if not institution, give street and number)		4b.	_	Location of Death	1	4c.	County of Deat Baltin	
		Gilchrist Hospice Social Security Number 16. Sex 17. Age	(In yrs. last birthd	(av) If	Under 1 Year	SON If Under 24 Hrs.	8. Date of Birt	h		thplace (State or Fore
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Funeral	ı	2891 Hilltop Drive			2110	2	nited S f Ameri	tates		
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Completed	ı	Elementary/Seconday (0-12) College (1-4 or 5-12th	+)		ot use retired) Homemak	er			Own Hor	me
Be	17	7. Father's Name (First, Middle, Last)			10memas		ne (First, Middle,	Maiden S		
임	L	James Preston Wilhelm				Louise	May Mar	ctin		
	1	Iga. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Ac	ddress (Street a	and Number or Rui	rai Route Numbei	r, City or	Town, State, Zip	o Code)
	L	Carl E. Myers (Husband)	289	l Hi	lltop 1	Drive, Ma	ancheste	r, M	laryland	21102
	20	0a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of D cemetery,		n (Name of ry or other plac	e) Mai	rch 11,	20c. Lo	cation - City or	Town, State
	L	4 Donation 5 Other (Specify)	New Lut			tery 2	2011			Maryland
	2	21. Signature of Funeral Service Licensee		l						pel, P.A.
Н	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,								r, Mary.	
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Completed							24a. Was a	an '		topsy findings availab
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ite: To		2 Accident Investigation 3 Suicide 6 Could not be		V		Yes 2 No				
I as I		4 Homicide determined 28e. Place of Injurbuilding, etc.	y - At home, farm (Specify)	, street, f	actory, office		28f. Location (S City or Tow		d Number or Ru	ral Route Number,
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Certificate:	L	29a. Certifier 1 Certifying Physician: To the best of r	amination and/or in	nvestigation	on, in my opinic occurred at the 29c. License	n, death occurred a e time, date and pla	at the time, date a ace, and due to the	nd place, e cause(s	and due to the	cause(s) and manner s stated.

State Registrar

DHMH 17 Rev 7/2009

Charles st

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Advisor (TO)

31. Date filed (Month, Day Year) (32. Pegistrar's Signature)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

				e Type or Pri							-		_	
		For State Am Registrar	end Item	State of M 23a per d	arylan l r.,g	913 913	partme 03/07/ Sertifica	2011 te of L	leaith a lhb Death	and IV	ientai Hy	/giene Reg. N	2011	07191
Physicia Medic		1. Decedent's Name		ast) Milburn							2. Date of De Month	D	ay Year 28 20	3. Time of Death 1204 p M
Examin		4a. Facility Name (if	not institution, giv	re street and number)			4b. Cit	ty, Town, p	Location o	of Death			c. County of Dea	
Funeral		5. Social Security N		Sex 7. Ag	e (In yrs. I		Month	der 1 Year s Days	If Under 2	24 Hrs. Min.	8. Date of Bir	rth	Howard 9. Bir	thplace (State or Foreign
Director		220-46-13 Usual Residence of	0/3	T L M Z M F	8	O Yrs	S. WORLD	3 Days	riouis	101111	(Month, De	28	(930 M	aryland
aryland a-f sho	ctor	10a. State	10b. County	1	10c. Cit		r Location							10d. Inside City Limits 1 ☐ Yes 2 🔀 No
the Ma a or 28a be notif	Funeral Director	Maryland 10e. Street and Nun	Howard	1		COT	umbia 10f. 2	Zip Code				10g. C	itizen of What C	
ath with	nera	5342 Flig	ght Feath		Tuor in 116		10 Mas Dos		045	nin? (Cno	oifu Voe or No		USA	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status1 Never Marri3 Widowed	ied 2 Married	12. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		5.	If Yes, sp	ecify Cuba	spanic Ong in, Mexican, Specify:		cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify: Wh	
72 hou n "natu Aedica	Completed		15. Decedent's cify only highest of	rade completed)		(G	ecedent's Us live kind of w	ork done d		of worki	ng	16b. l	Kind of Business	Industry
I within ygiene. her tha t, the I	e Cor	Elementary/Seco		College (1-4 or s	ō+)		isable					N	ever Wo	ked
be filec ental H ked ot ic even	To Be	17. Father's Name (F									e (First, Middle, orris	, Maider	Surname)	
should and M is mar		19a. Informant's Na					-		and Numbe	r or Rura	l Route Numbe		or Town, State, Zi	p Code)
l and 2 f Health tem 27 other to		Donald St 20a. Method of Disp		lburn, Bro			7 Bayl isposition (N		Ct. 1		re, VA	1	_ocation - City or	Town, State
Page 1 ment of ant: If i			☐ Cremation 3 ☐ 5 ☐ Other (Spec	Removal from State	С	emetery,	crematory of n Ceme	r other plac						Maryland
permit. Departimport any inj		21. Signature of Fur	neral Service Lice	Thomas (Grego	r	22 Name Mac Na	and Addres	ss of Facility	1 Ho	me, P.	A.	lle, MD	21228
		23a. Part 1. Enter the shock, or hear	he discase, or cor t failure. List only	polications that caused one cause on each line	the deat	h. Do not							TIC, III	Approximate Interval Between
Physician/ Medical		Immediate Cause (disease or conditio resulting in death)		a. Sept Due to or as	CONSEGU	5h	ock							Onset and Death
Examiner	_	Sequentially list co	nditions.	Urinar	y Tra	act I	nfect	ion						
executed an and rial-transit	camine	if any, leading to im cause. Enter Under Cause (Disease or i that initiated events	imediate rlying linjury	Due to (or as Possib)	le Pr	uence of): 1eumo	nia							
be executed sician and burial-transit	cal E	resulting in death) L	_ast	Due to (or as	a consequ	uence of):								
tificate ng phys	Medi	IF FEMALE:		d										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical Examiner	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 - Feta	al death	3		y				23d. Date of de Month	olivery Day Year
uires that t signed b	ρ	Part II. Other signifi	icant conditions	contributing to death b	ut not res	ulting in ti	ne underlyin	g cause giv	en in Part I.					o the cause of death? Probably 4 Kunknown
he law req ite has bee age 2 shou	Completed										24a. Was auto perfe 1 \sum Yes	psy ormed?	prior to death?	itopsy findings available completion of cause of
Physician: The lar r this certificate ha rral director, page 2	Be C	25. Was case referre examiner?	ed to medical	Hessital					ace of Deatl	h (Check		2 4	10] T T T	5 2 1110
Physic r this c eral dire	은 :	1 ☐ Yes 2 2 27. Manner of Death	No 1	Hospital: 1 X Inpati 28a. Date of inju		ER/Outpa	atient 3 🗌	DOA Othe	4 ∐ Nu		me 5 Resi		6 Other (Spec	cify)
eath. eath. or: Afte	Certificate:	1 ► Natural 2 □ Accident 3 □ Suicide	5 Pending Investigation 6 Could not		, Year)	inju	ry M	work			. DOSO1100 1	now inju	ry doddired	
ital or Att urs after d ral Direct lled in by		4 Homicide	determined	building, etc	Specify,)	·				City or Tox	wn, State	e)	ral Route Number,
ie Hosp n 24 hor ie Fune bleted fi	Medical	(Check 2	Medical Exam	vsician: To the best of niner: On the basis of e Practioner: To the	xaminatior	n and/or in	vestigation, i	n my opinic	n, death oc	curred at	the time, date a	and plac	e, and due to the	cause(s) and manner stated.
To the within to the complete		29b. Signature and t		wen			1 29	9c. License) 64	number 87			29d. Da	ate signed (Mont	h, Day, Year)
4		30. Name and addre	ess of person who	completed cause of d	eath (Item	-	e, Print)	RCC	LH			-		
Stat Registra	-	31. Date filed (Month	T;-Day, Year)	32 Registra			barle	0	,					

		1 - State Registrar	e or iviaryiani		tificate of D			leg. No.		(a) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
ysicia		1. Decedent's Name (First, Middle, Last) John Arthur Men	Z				2. Date of Deat Mar.	o 7	2ŎĨ1	3. Time of Death 4:43 A M	
Medic xamin		4a. Facility Name (if not institution, give street and 207 South Harrison Str				Location of Death		4c. Cou	inty of Death Ta1bo		
neral ector		5. Social Security Number 120–26–6450 6. Sex	7. Age (In yrs. Ia 77		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 3	Year) 1933	9. Birthp Count	lace (State or Foreign ry) New York	
zsa-i snow otified at	Director	Usual Residence of Decedent 10a. State Maryland Talbot	10c. City	, Town or Loc		ston			11	0d. Inside City Limits 1 ☐ Yes 2X No	
ust be n	Funeral D	10e. Street and Number 207 South Harrison St	ceet		10f. Zip Code	1601		10g. Citizen Unite c	of What Coun		
Important: It tem 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		1 Never Married 2 Married 1 If Yes	Decedent Ever in U.S d Forces? Yes 2 X No , Give or Dates.	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 XNo	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		Race - America Black, White, e cify: Wh		
er than "nat , the Medica	Completed by		eted) ge (1-4 or 5+)	(Give k	ent's Usual Occupa ind of work done of NOT use retired) Crical En	uring most of worki	ng		f Business Ind ed Stat Navy		
rkea our lic event	To Be	17. Father's Name (First, Middle, Last) John Arthur Merz, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Viola Rees									
z/ is ma r traumal		19a. Informant's Name/Relationship (Type, Print) Martha L. Merz / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 South Harrison St., Easton, Maryland 2160									
tant: If item lury or othe		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Metr	ace of Disposemetery, crem	sition (Name of	<u> </u>	Date	20c. Location	on - City or To	wn, State	
any inj		21. Signature of Funeral Service Licensee Aly	son K Tayl		Name and Addres	s of FacilityCren	mation S Baltimo	ociet re, M	y of Ma aryland	aryland d 21228	
cian/ dical miner the prival-transit	Medical Examiner	shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last d		Interval Between Onset and Death							
as	5 1	FFEMALE: 23c. If yes 23c. If yes 1			Date of delive Month	ry Day Year					
completed filled in by the funeral director, page 2 should be detached for use		Part II. Other significant conditions contributing	o 3 🗆 Prob	tribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available							
r, page 2	Completed	05 W					autops perforn 1 🗆 Yes 2	ned?	prior to con death? 1 Yes	npletion of cause of	
funeral directo	ate: To Be	27. Manner of Death 28a. □ 1 ☑ Natural 5 ☐ Pending	I Inpatient 2 E E Pate of injury Month, Day, Year)	ER/Outpatient 28b. Time of injury	Othe 28c. Injury work	4 ☐ Nursing Hot at 2					
in by the	Certificate:		lace of Injury - At hon uilding, etc. (Specify)	ne, farm, stre			28f. Location (Str City or Town		mber or Rural i	Route Number,	
leted fillec	Medical	29a. Certifier (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination	and/or investi	gation, in my opinio	n, death occurred at	the time, date and	d place, and	due to the cau	se(s) and manner stated	
сошр		29b. Signature and title of certifier	ret. To the best of my	Kilowiedge, d	29c. License				ned (Month, D		
		30. Name and address of person who completed David H. Smith, 8221		Condition	- 200 17	aston, Ma	ryland	21601			
Stat egistra	_		2 Registrar's Signatu	1. Aga	e 302, E						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAITIMORE 1 MONIUM toSP If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Yea Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Yrs **Director** 7-30-Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland **Funeral Director** 1 Yes 2 No timore 10g. Citizen of What Country? 10e. Street and Number items 23a 5 hAWNER 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No FR-MY
If Yes, Give 14. Race - American Indian, ural", or iten I Examiner r Black, White, etc þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify Yes, Give Year or Dates. 1951 and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) CACHER Be Maryland and 2 should be filed Health and Mental Hy 18. Mother's Name (First, Middle, Maiden Suman 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad Less (Street and Number or Rural Route Number, City or Town, other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Location - City or Town, State Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State Forest Vet. JAMISON 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CONKLING ase or complications that caused the death. Do not enter the mode of dying, such as partiac or respiratory arrest, 23a. Part 1. Enter the discase or of shock, or heart failure. List of Approximate one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ G disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to initial decause. Enter Underlying Cause (Disease or iinjury that initiated events Examine use as the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death 2 No be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown Records, 1 🔲 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed? Hospital or Attending Physician: The 1 \sum Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2X No မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1-Natural injury 5 Pending Division M 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of Anniquation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) License number 201 QVC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093

Registrar DHMH 17 Rev 7/2009

State

201

MARCH

PATRICK

2300 DULANEY VALLEY ROAD

M.D.

32. Registrar's Sig

ERNESTINE WRIGHT,

31. Date filed (Month, Day, Year)
NAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Marie Messinger 23, 2011 Grace 1329 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Oct. 31, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 XF New York Director 079-20-0608 Yrs 82 1928 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6510 Stoneham Road 20817 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) or other traumatic event, the Bookkeeper h and Mental Hygien 7 is marked other t 12 Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pasquale Graglia Antoinette Romeo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Lerner / Daughter 6510 Stoneham Road, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 🗴 🗆 Cremation 3 🗆 Removal from State Pinelawn Memorial March 5,2011 4 Other (Specify) Pinelawn, NY Cemetery 21. Sign sure of Juneral Service Lice yee 22. Name and Address of Facility Vanella Funeral Chapel, Inc. 2850 Long Beach Road, Oceanside, NY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Acute Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or imjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Aortic Stenosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnous Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of the Hospital or Attending Physician: The law autopsy perform death? perrormed? Yes 2 X No 2 🗌 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Tes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death Funeral Director; A 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 23, 2011 D67986 d address of person who completed cause of death (Item 23a) (Type, Print) Yuneng Li, MD 8600 Old Georgetown Road Bethesda, MD 20814 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Marie

	Registrar 1. Decedent's Name (First, Middle, La	and)	Ce	rtificate of I	Death	2. Date of Death	g. N/6, U	3. Time of Death		
ician dical	Otis	McFall				Month MAR	5 201	ar 11:40PM		
iner	4a. Facility Name (If not institution, give SINAL HOSPITAL	ve street and number) OF BALTIMORE		4b. City, Town, or BALTIMO	Location of Death		4c. County of E	,		
1	Social Security Number 6. S	Sex 7. Age (In yrs.			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	n/a Birthplace (State or Foreig Country)		
r	250-60-7482 1 Usual Residence of Decedent	1⊠M 2□F 77	Yrs.			Nov.1,1		S.C.		
	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limit		
Director	MD n/a		Bal	timore				1 Styes 2 No		
ä	10e. Street and Number	- CL 3L 2:	Б	10f. Zip Code 2121	7	10	g. Citizen of Wha	t Country?		
Funeral	1510 W. Mosher 11. Marital Status	St. Apt. 3		Was Decedent of H If Yes, specify Cuba		ecify Yes or No-		American Indian, Vhite, etc.		
by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:	riioari, oto.		Black		
ted k	15. Decedent's E	Year or Dates:		dent's Usual Occup			6b. Kind of Busine			
Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	1)	ng				
	17. Father's Name (First, Middle, Last)		Bartend	18. Mother's Name	(First, Middle, M.	Bar			
To Be	Otis McFa				Olli		Bridges			
	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street				te, Zip Code)		
	Julia R. McFal 20a. Method of Disposition			2 Robert			nore, Mo			
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crei	matory`or other plac	e)		· ·			
	21. Strice of Fun all Service Licer		2:	Name and Addres	ss of Facility			imore,Md		
1		ST.			SCRUG PRESTON			ME MD 21213		
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.		ter the mode of dyin	g, such as cardi a c (or respiratory arre	st,	Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONI Due to (or as a conseq						_		
	Comment of the life of the lif	CONGESTI		ART FAIL	URE					
iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	шенка Ж.					=		
Examine	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
<u>a</u>										
Physician/Medio	IF FEMALE:	00. 15								
cian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of delivery Month Day Year		
hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown									
ρ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			te to the cause of death?		
eted	PLEURAL EFF	1(102)					s 2 □ No 3 □			
Completed	CARDIAL ARR					24a. Was an autopsy perform	prio			
Be Co	25. Was case referred to medical	117 [F MIL	-		26. Place of Death			Yes 2□No		
၉	examiner? 1 Yes 2 No	Hospital:			4 D Nursing 110	me 5 Resider		Specify)		
Certification:	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Work	yat ⟨? Yes 2 □No	28d. Describe hov	v injury occurred			
ifica	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 290 Place of Injury At h	ome, farm, str					or Rural Route Number,		
Sert	V		City or Town, State)							
Medical	29a. Certifier (Check only one) Certifying Pr 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or ir	th occurred at the tire evestigation, in my o	er as stated. due to the cause(s)					
Mec	29b. Signature and title of certifier	and mariner stated.		29c. Licens	e number	29	d. Date signed (N	fonth, Day, Year)		
	Marsiba			Doo	61959	1	MAR 5,	2011		
	30. Name and address of person who	CINCAL HALPI	TAL M	C BAITIM	DRE					
	MININ SIDIKE INCL									
tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature							

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Daniel Joseph McGonigle, Sr. March 6, 12:07 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Min. Year 1925 Maryland Hours Oct. 18, 206-14-9321 Director 85 Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at within 72 hours after death with the Maryland Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Baltimore Timonium 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: Completed 3 Nidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmetic. Elementary/Seconday (0-12) College (1-4 or 5+) Material Expediter Westinghouse Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel J. McGonigle Loretta Larkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel McGonigle Jr., Son 5547 Oakland Road; Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Dulaney Valley 3/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Servi Licenses MOIOSD 23a. Part 1. Enter the disease, or complications that caused the death. Do ot enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause of Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law certificate has autopsy performed?
☐ Yes 2- No 1 Tes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2. XNO မ 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after of Funeral Direct filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотрыете within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d Date signed (Month, Day, Year) 29b. Signature and title of cer 0 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar ERNESTINE WRIGHT, M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2011 9:35 PM Julia Appleton Metcalf March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Broadmead Health Care Center Cockeysville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Months Days Hours (Month, Day, Year) Mar 13, ^{Country)} Vi<u>rg</u>inia **Director** 1916 218-42-1326 Mar Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d, Inside City Limits Director 1 Yes 2 No Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13801 York Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 - No 1 Yes 2 No Specify: If Yes, Give 3 ₩idowed 4 □ Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor White George George Clifford Appleton and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Scott Metcalf /Daughter 9301 Linden Avenue Bethesda, MD 20814 Itimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Mar 4 Donation 5 Other (Specify) Beltsville, Maryland 2011 Chesapeake Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility C Cremation and Funeral Alternatives 8717_Green_Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Physician: The law requires 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown been YPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manne Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 5 \square Pending 1 🖳 atural Division 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death d at the time re and title of certifier 29d. Date signed (Month) Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, F 0 31. Date filed (Month, Day, Year) MAR 08 Registrar

✓ DHMH 17 Rev 7/2009

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 5. Thien Du Nguyen 2:08 P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 18, 1929 **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Hours **Director** 634-36-0122 81 Yrs. Vietnam Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "notice." 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 X Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 509 E. Randolph Road 20904 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: Asian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Muong Van Nguyen An Thi Trinh 19a. Informant's Name/Relationship (*Type, Print*) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacklyn ThuyTien Nguyen 2233 Havencrest Dr., Houston, TX 77038 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Resthaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/18/2011 Houston, TX 21. Sign ture of Funeral Service Licenses 2. Name and Address of Facility Winford Funeral 8514 Tybor Dr., Home ne 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Unknown Malignancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transil Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death ☐ Yes ∠ ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes Mellitus, COPD Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 X No After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? BB 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 🗌 Yes Investigation 2 🗌 No within 24 hours after death

To the Funeral Director; of the formula of the completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗔 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5 D0068681 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charo Maheshwary, M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Genve Anna Orzolek 201^{Year} 3 1:35p M **Medical** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 506 Holly Hunt Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Country) Delaware Hours 221-10-5859 June 28 Director 88 Usual Residence of Deceden or 28a-f shov 10b. County 10a, State filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Middle River MD 1 Yes X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 506 Holly Hunt Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify: White Completed 3 Divorced 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Western Electric 12th Administrative Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stanislaw Orzolek Ana Siefezrk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan DeSimone /niece 1201 Captains Court Towson MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Buria / Cremation 3 🗆 Removal from State Holy Rosary Cemetery 3/8/1 Baltimore MD 4 Donation 5 Other (Specify) 21. Sign sture of Funetal Salvice Licenses 22. Name and Address of Facility 300 MAce Ave. Balto. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause an each line. Funeral Home of Essax 21221 Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition OLURALE OVONOYY Medical resulting in death) Due to (or as a consoquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to tor as a consequence of Exami the Hospital or Attending Physician: The law requires that the death certificate be executed nevte physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been sig 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate ha death? 1 Yes 2 No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tyes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident
Suicide neral Director; A 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) DO055171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D Arenne Boltima Jebastich 3023 K tagtern

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Darlene Jeanette O'Reilly March 3. 20°11 9:10 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Burtonsville Holy Cross Sanctuary Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 495-32-5462 July 5, MO Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland notified at Director Greenbelt Prince George's 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be a Funeral USA 20770 10-C Hillside Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4x Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker æ 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Anna Boor traumatic John Hrevus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $9521\ 49th\ Pl.\ College\ Park,\ MD\ 20740$ permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Justine M. O'Reilly, daughter Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 3/7/2011 1

Burial 2

Cremation 3

Removal from State Beltsville, MD 4 Donation 5 Other (Specify) MO15322. Name and Address of Facility RAPP Funeral & Cremation Secs. 21. Signature of Funeral S 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine المام death certificate be executed inding physician and use as the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Pregnant at time of death 5 Other (specify) Month Day Year the a Unknown Hospital or Attending Physician: The law requires that the signed by the Part II. **Other** s<mark>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy performe this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred **4fter** 1 Natural injury 5 Pending Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 00069829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 Smith Avenue, Sull 203, Baltime MD. HSEEN Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 2, 2011 9:45 P M WILLIAM ASBURY PRICE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan。 31 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Year 1923 Days Min. 1 X M 2 □ F Maryland Director 201-24-0066 88 Yrs. Jan. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 🛂 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1415 St. Francis Road 21014 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married by should be filed within 72 hours after White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck Driver General Hauling Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter A. Price Margaret (unk) Fletcher Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Paul Price / Son 1207 Jomat Dr., Joppa, Maryland 21085 Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bedford, PA Bedford Co. Mem. Park 3-8-11 . Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ DEMENTIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Exami Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗆 Yes 2 🗶 No 1 Yes 2 No Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\mathbb{X} \) No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year).

P. E

2011

MARCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 4. Physician/ DOROTHY MARY GRAUER PRICE 8:16 A^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEART HOMES OF LUTHERVILLE Lutherville Baltimore County 5. Social Security Number 8. Date of Birth (Month, Day Y June 20 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 💢 F ^{/ea}19<u>23</u> Mary Land 216-14-4395 87 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location Examiner must be notified at Funeral Director 1 Yes 2 X No Maryland | Baltimore County Lutherville ō 10e. Street and Numbe 10g. Citizen of What Country? 23a filed within 72 hours after death with 1420 Front Avenue 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, State of Maryland Elementary/Seconday (0-12) College (1-4 or 5+) School Store Manager College Education other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | 7 is marked c ၉ Page 1 and 2 should be William George Grauer Helen Emma Kirkwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Gary W. Price (Son) 8528 Harris Avenue, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important: If ite
any injury or ott Dufaney "Valley" Mem. Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 3/8/2011 Signature of Fune all Service licensee MTTCHELL WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Martin D. Lawson Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, he sing to immediate cause. Enter Underlying Examiner Due to for as a consequence of sician and bunial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year ed by the a detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy perform performed? Yes 2 No 1 Yes **Division of Vital** director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 M Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hou

To the Fune

completed fi 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 4680240 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

en

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.

Anne Abi, CRNP, 6701 North Charles St., #4105, Towson, MD 21204

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Augsburg Lutheran Home Baltimore Baltimore 8. Date of Birth
(Month, Day, Yea
Jan - 26, **Funeral** Social Security Number Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months 1 - M 2XX Hours New York 88 **Director** 059-18-8729 Yrs. Jan. 1923 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD Baltimore Baltimore 1 🗌 Yes 🗶 🗓 No 10e. Street and Numbe 10g. Citizen of What Country? 6811 Campfield Rd. Apt. 21207 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. Completed XXWidowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Eastman Kodak other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked o မ Howard J. Snow Hope Vivian Pollard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Joan Kling / Daughter 43 Slavin Ct. Baltimore, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o of XX Burial 2 Cremation 3 Removal from State Garrison Forest 3/11/11 Owings Mills, MD Donation 5 Other (Specify) eterans Cemeterv 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Service License 21. Signature of Low | 1605 Reisterstown Rd. Owings Mills, MD21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ▼No Day Month Year Pregnant at time of death signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown s been si should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performed? Yes 2 No death? this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ᅆ 1 Inpatient 2 I ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Liter death.

**I Director: After th.

**In by the fire. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Matural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in within 24 hours a

To the Funeral D

completed filled i Hospital Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year)

ng and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perffl, G913, 3/15/2011, WS

State of Maryland / Department of Health and Mental Hygiene 07204 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elwood Lester Rothgeb, III Physician/ Martch 3 201 far 6:30A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 110 Mountain Rd. Fallston 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 5 Social Security Number 217-78-3631 Age (In vrs. last birthday) (Month, Day, Year) Months 1**X**□ M 2 □ F 49 Days Hours Min Maryland Yrs. **Director** 78 3031 July 10, 1961 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 No Md. Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Mountain Road 21047 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Carpenter Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elwood Rothgeb Mary S. Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fallston, <u>Maureen Rothgeb</u> Mountain Road <u>Spouse</u> Md. 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview 3-7-2011 Fallston. Md. 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 21. Signature of Funeral Service Licensee 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ntavo Physician/ yo cardia disease or condition Medical resulting in death) Due to (or as a conse un nce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence or). attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No To the Funeral Director; After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for i Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEEP VEIN THROW BOSIS 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 1069 enter Wary Kman leur Date filed (Month, Day, Yea NAR 0 8 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Day2011 Physician/ Christine Hope Rabor March 4, 9:15 A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 M 2 X F July 28, Hours Philippines Director ′1970l 216-06-3088 40 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland D partment of Healtt and Mental Hygiene. Iniportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic average. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carrol1 Manchester 10e. Street and Number 10g. Citizen of What Country? Funeral 3054 Ciesta Court 21102 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Asian ò 1 Never Married 2 Married Saltimore, Maryland 21215-0036 SpecifyPacific Islander 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Contracts Analyst Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert R. Lardizabal Mildred A. Ponce de Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph S. Rabor 3054 Ciesta Court; Manchester, MD 21102 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View Mem. Park 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Sykesville, MD 3/8/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee Tell M00333 1630 Edmondson Avenue: Catonsville 23a. Pao 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final √nysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year Yes been signed by the s Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 Yes 2 No Certificate: 28b. Time of Natural Accident 5 Pending Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sic nature ai title of certifier 29c. License numbe 11000 Name and address of person who completed cause of death 4105 Baltineare, MD SIROY 10 State MAR 0 8 2011 Registrar

DHMH 17 Rev 7/2009

Physician/ Medical Examiner Funeral **Director** permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

Please Type or Prir						gible.		
State of Ma	•	artment of He				1 1	0700	_
Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	ath	2. Date of Dea	Reg. No.		0/20	<u>b</u>
Michae	el Jerome	Ryan		Month March	Day	$01^{ m Year}$		
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo	cation of Death		4c. Count	y of Deat	h	
Gilchrist Nursing Center		Towson						
5. Social Security Number 219-30-3681 Sex 1	(In yrs. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day July 2	20,1936	g. Birl Cor Mar	hplace (State or Fore untry) y Land	∍ign
10a. State 10b. County	10c. City, Town or Lo	cation					10d. Inside City Lim	nits
MD Baltimore			Dund	alk			1 ☐ Yes 2 🖾	No
10e. Street and Number		10f. Zip Code			10g. Citizen of	What Co	untry?	
7843 Rockbourne Road 11 Marital Status 12. Was Decedent Ev	orin II C 12)	21: Was Decedent of Hispa	222	acify Vac or No-				
11. Marital Status 12. Was Decedent Evarmed Forces? 1 □ Never Married 2 ☒ Married 1. □ Yes 2 ☒ N	10	f Yes, specify Cuban, N	Mexican, Puerto	Rican, etc.)		ce - Ame ick, White		
3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	I ☐ Yes 2 🔀 No S	Specify:		Specif	y:	White	
15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupatio kind of work done durii O NOT use retired)	n ng most of work	ting	16b. Kind of I	Business	Industry	
Elementary/Seconday (0-12) College (1-4 or 5+ 1 2 Years	-)	ck House St	upervis	or	Stee	l Inc	lustry	
17. Father's Name (First, Middle, Last)		18		ne (First, Middle, I	Maiden Surnan	ne)		
Charles Ryan			Mary K					
19a. Informant's Name/Relationship (Type, Print) Mrs. Joan M. Ryan (Wife)	19b. Mailir 7843	ng Address (Street and 3 Rockbouri	Number or Run ne Road	al Route Number, Dunda1k	City or Town, Mary	State, Zip land	21222	
20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		sition (Name of natory or other place) Cemetery	į	Cate / 2011	20c. Location	-	_	nd
21. Signature of Funeral Service Licensea) 22	. Name and Address of Duda-Ruck	f Facility Funera1	Home of	Dunda	1k,	Inc.	
23a. Part 1. Enter the disease, or or implications that caused to	the death. Do not ente	7922 Wise				and		
shock, or hear fadure. List only one cause on each line. Immediate Cause (Final disease or condition	imice	altena)	Canc	v			Interval Between Onset and Death	
resulting in death) Due to (or as a	consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):						2	
Cause (Disease or iinjury that initiated events c.	consequence of):					\rightarrow		
	consequence on.							
d								_
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome o	f pregnancy	Ectopic pregnancy				ate of del	•	
1 Yes 2 No 9 Unknown	time of death 5	Other (specify)		-	M	onth	Day Year	
Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause given	in Part I.	23e. Did to	. 2		the cause of death?	
				24a. Was a	ın 24b.	Were aut	topsy findings availab	ble
				autop perfor 1 Yes	sy med? 2 No	death?		of
25. Was case referred to medical examiner?		26. Place	of Death (Chec	k only one)				
1 Yes 2 No 1 Inpatier 27. Manner of Death 28a. Date of injury	nt 2 ER/Outpatien	it 3 🗆 DOA		ome 5 Residence 28d. Describe ho			ity hispile	
Natural 5 Pending (Month, Day,	Year) injury	work?	2 🗆 No	Zou. Describe in	ow injury occur	ieu		
3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (St City or Town		er or Rui	Imore Co. Inhiplace (State or Foundly) Ind. Inside City Lift of the Cause of death Probably 4 Unkroutopsy findings availated. Inc. 21222 Approximate Interval Between Onset and Death Probably 4 Unkroutopsy findings availated of the Cause of death Probably 4 Unkroutopsy findings availated of the Cause	
29a. Certifier (Check 2 Medical Examiner: On the basis of example 2 Medical Examiner (Check 2 Medical Examiner)	amination and/or invest	igation, in my opinion, o	death occurred a	t the time, date ar	nd place, and du	ie to the c	ause(s) and manner st	stated.
only one) 3 Certifying Nurse Practioner: To the b	est of thy knowledge, c	29c. License nu			cause(s) and m 29d. Date signe			
A Sharehon	oth (Itam 02-) (Fine 5	05	8303	>	Merch	2	2011	
30. Name and address of person who completed cause of dea) 6701	N. Cua	ncs s	T Pan	120 N	M)		
31. Date filed (Month, Day, Year) NAR 0 8 2011	's Signature	الما						
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 5, 2011 11:20 ам M. Ryder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edenwald Towson Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 및 F June 13, 1915 Director 95 Mary Land 212-03-7338 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road #105 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miller Marie Kling Jacob Henry Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Peacock-nephew 613 N. Paca Sr., Baltimore, MD 21201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Nourial 2 Cremation 3 Removal from State Baltimore Cemetery 3/11/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Stale disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal deat
4 ☐ Pregnant at time of death
9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by $\mathcal{L}\mathcal{N}\mathcal{R}$ Division of Vital Records/ 2 00 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred work? iniury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. redical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) R154032 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 Southerly Rd Towson, MD Susan Schen CRUP 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 7/2009

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Registrar

31. Date filed (Month, Day, Year)

8 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** Mary A. Scheele 4:40 P M 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A 8. Date of Birth (Month, Day, Year)
Nov 21, 1 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 1 □ M 2 🗓 F 216-14-7488 87 1923 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Mudical Examination ust be multified as 1 ☐ Yes 2 X No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6107 Burnt Oak Road 21228 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status should be filed within 72 hours after on Mental Hygiene.

marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H Be John Fitzgerald Katherine Hughes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 3 Department of Health Important: If item 27 I any injury or other tra once. Diane Scheele, Daughter 6107 Burnt Oak Road Catonsville, Maryland 21228 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 03/07/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee MacNabb Funeral Home, P.A. 301 Frederick Road Cantonsville, Maryland 21228 Thomas Gregor Momow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 0045 PIVEDMON. Sequentially list conditions, if any leading light immunity cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse wence of burial-tran Due to (or as a consequence of): attending physician for use as the buria 8 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 st 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 🗷 No Hospital or Attending Physician: After this certifii funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Stephens 9:48A M Jessie M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3801 Schnaper Drive Apt.135 Randallstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Ye eb 24, 1 □ M 2 🛛 F Hours Year! Maryland 217-16-3216 89 Yrs 1922 Director Usual Residence of Decedent 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Randallstown Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 USA 3801 Schnaper Drive Apt.135 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2🌠 No Specify: Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City Case Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John H. Blount Eva Mundell 19a. Informant's Name/Relationship (Type, Print) 21133 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health au Important: If item 27 is any injury or other trauonce. <u>Sheila M. Stovall, Daug</u>hter 3801 Schnaper Drive Apt.135 Randallstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 \square Burial 2X1 Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 03/05/11 Baltimore, Maryland ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licen Thomas Gregor homa Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Cardiovascular Disease Immediate Cause (Final Onset and Death Physician/ ATherosclerofic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esque shally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached for the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 🖺 No 1 Tes 3 Probably 4 Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Y Other (Specify) 1 Yes 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred injury ✓ Natural 5 Pending . √atural
☐ Accident
☐ Suici Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

MSky up amel 1) 29c. License number 29d. Date signed (Month, Day, Year) DOUS7465 314/11

State Registrar

DHMH 17 Rev 7/2009

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5-203 - Baltimore, MD. 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

22. Registrar's Signature

N . 5 Ray apakse, M.D

MAR 0 8 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Marie Margaret Schuler 201 ٥ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tranklin Saugre HOS Baltimore Roseda 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 耳F Days Hours (Month, Day, Maryland 216-28-4386 Yrs Director Aùgust Usual Residence of Decedent show "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2X No Middle River Balto. Md 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code Funeral 21220 2239 Firethorn Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, 1 Never Married 2 Married Completed by 72 hours after 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) College Transcript Specialist Be Itimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked of ဂ္ Sarah C. DeVere Henry J. McGinnis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie A. Snyder Niece Fallston, Md. 21047 Department of Health Important: If item 27 any injury or other trong. Surrey Court Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 3-7-2011 Balto. Md. Gardens of Faith 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home Nottingham, Md. 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Picatory disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner b. Intersity tich lung 400 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) PESITIVE Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) and that initiated events resulting in death) Last been signed by the attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ours after death.

eral Director: After this certificate has I filled in by the funeral director, page 2 s performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital: 2 No Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatura hd title of certifier 2 250000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive State Registrar

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DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 930 PM Richard P. Slifker :3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FRANKLIN Square Hospital Rosedal Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year
Sept. 12, Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Director 216-32-3567 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown yinjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 62 Cool Breeze Drive 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: SLIFKER If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 🙀 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer AT&T 4 vrsBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Slifker Anna Goeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Serrano /daughter 6238 Latchlift Court Elkridge MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rob. Place of Disposition (warrie or cemetery, crematory or other place)

Bayview Crematory 3/7/11 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore MD 21. Signature of Juneral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or charge cations that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** denocarcinoma of the lung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day signed by the at I be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed hupertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 횬 1 Yes Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: Natural 28a. Date of injury 28b Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, 5 Pending 1 Tes 2 🗌 No Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge; death occurs d at the time, date and place 3 29b. Signature and title of certifier D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RD, Surk 300 BALTO UD 21237 Levin Schendel 9114 31. Date filed (Month. Day Year) . 32. State Registrar

DHMH 17 Rev 7/2009

Richard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FLORA SMITH Day 10:50 PM 201 Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** BIN HOJPITAL SECOUNS BALTIMORE If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min. (Month, Day, **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director Baltimere 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. College (1-4 or 5+) Be မ 19th. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral 21239 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Interval Between Onset and Death FAILINAE RESPIRA TORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** SE12873 Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury PNEWMONIA attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HUPER TENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? DIAMETES MELLITUS 24a. Was an s certificate has b director, page 2 s 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🛛 No Other: ပ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JANET - MUST SEL MO V BALTINDRE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No.-Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Smith Anna Louise 2:13A M 2011 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Essex Lighthouse Senior Living Baltimore Co. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Min. Months Days Feb. 9 1 🗆 M 2 🔀 F Hours , 1931 Country) 80 MD Director 214-26-8011 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Dundalk MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21222 United States 3905 Glenhurst Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 27 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: White Completed 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing 8 Years Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna F. Smith George W. Betz of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Bergen Court Bel Air, Maryland 210 Mrs. Brenda Torrance(Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Hilltop Service Corp. 3/8/2011 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licer Buda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate each line. Interval Between Onset and Death Immediate Cause (Final Chysician/ MIDUA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate has Yes 2 To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \sum Nursing Home 5 \sum Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury_at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated mature and title of certifier completed cause of death (Item 23a) (Type, Print) Stemmers Run RD 31. Date filed Registrar's Signature State Registrar

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		Registrar 1. Decedent's Name (First, Midd	He Leet)	Certificate	of Death			2. Date of De	Reg. No. 4			
Physicia ical Exami				nuch				Month March 2,	Day Ye	3. Time of Death 2035 hrs		
		Andrew Ri 4a. Facility Name (if not institution	sley Stamb	augn er)	4b. City, To	wn, or Loca	ation of Death		4c. County	of Death		
		St. Joseph's Hospital			Tows	n			Baltimo	ore County		
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthda			f Under 24Hrs		irth(MM/DD/YYY	Y) 9. Birthplace (State or Foreign		
Director		218-90-1333	1XM 2F	33	Yrs. Months	Days	Hours Min	Sept.	7, 1977			
b		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Lir		
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ryland a-f sh t once	ţ	MD Ba	1timore	Luther	Ville 10f. Zip (Code		I	10g. Citizen of W			
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permit Pages 1, and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	424 Talbott A	12. Was Decede	nt Ever in U.S. 13	Was Deceder	21093 t of Hispanie		pecify Yes or N		USA e - American Indian, Black,		
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be filed within 7 ntal Hygiene. rked other than ent, the Medica	Bec	Clay Stambau						e11	Malaon camana	-,		
Men Men ic eve		19a. Informant's Name/Relations		19b. Ma	iling Address				mber, City or Tow	wn, State, Zip Code)		
d 2 sho th and n 27 is		Clay Stambaugh	, Jr./Fathe	r 424	Talbot	t Ave	. Lut	hervill	le, MD 2	1093		
FHeal Fiter		20a. Method of Disposition 1 X Burial 2 Cremation	2 Pomoval from 9	20b. Place of Dis	position (Name r other place)	of cemeter		ch 7,	20c. Location	- City or Town, State		
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partm	1	21. Signature of Funeral Service Learns 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Vall										
		Michael J	Flagie		10 W. P	adoni	<u>a Road</u>	Timor	nium, MD	21093		
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cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as t		Part II. Other significant condit	ions contributing to dea	th but not resulting in t	ne underlying o	ause given	in Part I.	23e. Did t	obacco use contr	ribute to the cause of death?		
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tal or Attending Physician: The law requires that it is after death. **In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed	clonazepam						24a. Was		Were autopsy findings availa		
e law te has ge 2 s	Ē	Стопадеран							ormed?	prior to completion of cause of death?		
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ysicia his ce direct	o Be	examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 🗸 ER/Outpat	ent 3 DO	A Other	4 Nursin	g Home 5	Residence 6	Other:		
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or At after d Direc	띭	3 Suicide 6 Coul	d not be 28e. Place of	njury - At home, farm, s	treet, factory, o	ffice buildin			Street and Number	er or Rural Route Number, C		
To the Hospital or Attending Physician: The law requires that the death certificate be execu- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Certification: T	4 Homicide	mined (Specify)	reside	nce			424 Tal	bot Ave	. Lutherville		
E Ho 24 ! Fun etely		29a. Certifier (Check only one) Certifying Pl	nysician: To the best of miner:On the basis of ex	ny knowledge, death or	courred at the ti	me, date an	nd place, and	due to the cau	se(s) and manner	r as stated		
A = A = 1	Medical	29b. Signature and title of certifie	and manner stated	l.		icense num		t the tille, date				
To the within To the compl		200. Olganoral and the or certific	1						March 3, 20	ed (Month, Day, Year)		
To the within To the compl	2	1000	W Da n/									
	2	Carae	Hell	du		D.C.M.E.			Iviaicii 5, 2			
To the within within the complete compl	2	30. Name and address of person Carol Allan, MD As:	who completed cause of sistant Medical Exa					 D 21223	March 5, 20			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:35 PM March 2011 Thelma May Sweeney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Vantage House – Cedar Place Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) 1 □ M 2 🕱 F Days (Month, Day, Year) 1914 Hours Ohio Director 579-07-7370 96 Nov Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am priging or other traumatic event, the Medical Examiner must be notified ** once. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Maryland Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 5400 Vantage Point Road 21044 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Assistant Publishing Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Estella May Bander Thomas_Franklin James 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denby Dr. Sykesville, MD 21784 Kathleen Beard / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 3/09/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Compression Fracture disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Dav Yea Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe 1 🗆 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending s after death.
I Director: Aft id in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) March 7, 2011 D47447 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 v Cedar Lane, Suite 103 Columbia, MD 21044 Andy Lazris 6334 31. Date filed (Month, Day, Year) 22. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

11-01713 Julia M. Smith Please Type or Print In Black Indelible Ink. Ensure All Copies Are Legible.

ulia M. Smith	1	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No. 201	07217
Physicia		Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death 3.	. Time of Death
Medical Examir			1917 hrs
	•	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital 4c. County of Death Baltimore	
Funeral		5 Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthp	
Director		13987-0572 1 M 2 F (3 Yrs. Months Days Hours Min. 8-30-1947 Foreign County	Carolina
		Usual Residence of Decedent	
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th the Maryland 23a or 28a-f sho	Director	11 Achla - Hill Carry 1 21234 (15A	
with the ns 23 m			n Indian, Black,
death ir item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	OV
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2 hours	g -	15. Decedent's Education (Specify only highest grade completed) Solution College (1-4 or 5+)	,
036 ithin 7 ne.	Completed	Client ASSOCIATE / Nero	×
1215-0036 d be filed within 72 hours a fental Hygiene. narked nther than "natura event, the Medical Examin			> >
	To Be	19a. Informant's Name/Relationship (Type, Pt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z	(ip Code)
and 2 shou fealth and N tem 27 is n traumatic		Manda Smith Drughter 14 ASh larth 11 Ct. Balto Miss	212
re, MC 1 and 2 sl 'Health ar fitem 27	Ī	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To crematory or other place) 1 Burial 2 Cremation 3 Removal from State Creen Mount Cemetery	
	-	4 Dométion 5 Other Specify:	re, 140
Baltimore, M permit, Pages 1 and 2 Department of Health Important: If item 2 injury nr other traus		21. Signature of meral since Licensee 21. Vine and Address Facility requestion eval Sor	vices
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Cardiovascular Disease	Death
Examiner		or condition resulting in death) Due to (or as a consequence of):	
	5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
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uted 1d ransit	Ĕ	events resulting in death) Last Due to (or as a consequence or). d.	
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tox 68760, eath certificate be attending physic for use as the bur	₩.	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da	y Year
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Bo ne deat t the at	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	e cause of death?
Division of Vital Records, P.O. Box 68760, rad or Attending Physician: The law requires that the death certificate be and red death. **In Director** After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burit	þ		
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of Vital Records ing Physician: The law requi After this certificate has been inneral director, page 2 should	ğ	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	
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SiOI Attend r death ector: by the	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura	al Route Number, City
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Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the			f. cause(s)
To the within To the comple	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mont	
	2	O.C.M.E. March 3, 2011	,
		30. Name and address of person who compiled 1 cause of leath (Item 23a)	
MV	6 N	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
		37 OR 71 CM	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death March 8:15A M Physician/ 201 XCOC Medical ility Name (if not institution. Town, or Location of Death 4c. County of Death Examiner Kandallstown tospice 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Mogr,9ay, 19 1**₩**0 м 2 🗆 ғ **Director** 28a-f show death with the Maryland at 10a State 10b. County City, Town or Location 10d. Inside City Limits Director Baltimore Examiner must be notified 1 Pes 2 □ No 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21207 eston Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 2 Married "natural", or 1 Never Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify. Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working lift. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) Conege (1-4 or 5+) ervices aiver other traumatic event, Be filed Name (First, Middle, ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked tarrison 19b. Mailing Address (Street and Number or Rulel Route Number, City or Town, State, Zip Code) 21245 mant's Name/Relationship (Type, Print) Brother J. Hollings the 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Services re of Funeral Service Licensee any in once. 23a. Part 1. Enter be disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final neet and Death Teadem Ph sician/ u Runax disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence or) ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical Box 68760 attending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown signed by the a Yes 2 No g Unknown P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Were autopsy findings available prior to completion of cause of has autopsy page perform death? certificate 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) ensunear 2 No Other: 1 Yes မြ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 D Other Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of berson who completed çause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6.63 a.M. William Irvin Slacum, Jr. 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a_Facility Name (If not institution, give street and number) Examiner Health Care Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year Oct. 5, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1942 Maryland 219-38-0054 68 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedfoal Examination and once. 1 ☐ Yes 2 ☐ No Director MD Baltimore Lansdowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 USA 2108 Gaylawn Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Roads Commisson 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Irvin Slacum Sr. Ruth E. O'Neil 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2108 Gaylawn Drive Lansdowne Maryland 21227 Gail Slacum-wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition HX Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park Mar. 5,2011 ELkridge Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc Signature of Junaral S 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MUDCANGLIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a p, leading to him edictions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner saw requires that the death certificate be executed burial-tran the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 I Unknown 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy The 2 1 No 1 ☐ Yes 2 1 No 1 ☐ Yes Vital or Attending Physician; 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 2 ER/Outpatient 3 □ DOA 1 Inpatient Medical Certification: To Division of After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

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30. Name an

31. Date filed (Month, Day, Year)

MAR 08

Avene

Baltimore, MD

address of per on who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 1 Physician/ ^D2011 Sickler 9:24 Рм Candice Renee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 409 Greenland Beach Road Anne Arundel Curtis Bay Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 □ M 2 🛚 F Months Augnth, Day Year) 1973 Correxas 220-82-3922 37 **Director** Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Curtis Bay 1 Yes 2 No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 409 Greenland Beach Road United States 21226 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 7

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Emergency Medical Technician Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed h and Mental H 7 is marked ot ၉ Michael Holcombe Shirley Steffen other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Donovan Sickler - Husband 409 Greenland Beach Road, Curtis Bay, MD 21226 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 3-7-2011 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or compilirations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final CERICAL Physician/ ANDLE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) this certificate has been signed by the attending physician and rai director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by UROPATHY RSTUCTIVE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 1 🗌 Yes 2 🗐 No **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse exaction or to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse exaction or to the cause of 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 12/11 Kulmis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOLD RITCHIE HWY, PASADENA, MD 21122 KUHNU MID.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year March 7, 2011 **Physician** 3:25A WILLIAM COCHRAN SADTLER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Baltimore Keswick If Under 1 Year | If Under 24 Hrs. 8, Date of Birth Months | Days | Hours | Min. (Month, Day, 04/23/1927) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 M 2□F 83 Maryland 220-22-9690 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner in ust be notified at Maryland Baltimore 1 ☐ Yes 🗶 No Towson Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21204 USA 1601 Ruxton Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No WWI 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Yes. Give Specify. ۵ 3 X Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Sadtler Cynthia Cochran ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11564 Worcester Highway Showell, Maryland 21862 Cynthia Sadtler Ayd DTR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1,□ Burial 2 🛱 Cremation 3 🗆 Removal from State 03/08/2011 GreenMount Crematory Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc gnature of Funeral Sen 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 005400 HOME /Medical Due to (or as a consequence of): Examiner Unkrow Deventis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No after death.

Director: After this certific
I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled 24 hours a Moretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 hou

To the Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 20000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Salvie

31. Date filed (Month, Day, Year),

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404 24 BEIT MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 10:40 M march 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Couw OWARC 6. 8ex 1 X M 2 □ F 9. Birthplace (State or Foreign Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day Funeral Country) Months Min. Hours 115-21-Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20902 20a. Method of Disposition City or Town, State 20b. Place of Disposition (Name of ☐ Burial 2. Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service License any ir 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 215le Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Duri to (or as a our sequence of) if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy death? Yes 2 No 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No ျ 1

✓ Inpatient 2

ER/Outpatient 3

DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying there Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and titl 2011 of person who completed cause of death (Item 23a) (Type, Print

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval inte	_			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval inte	0.6			
Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Wedical Examiner Physician Medical Examiner				
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Between			
Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of):				
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Space of the significant conditions contributing to death but not resulting in the discertainty at 1. 1 Yes 2 You 3 Probably 4				
For Door of the control of the contr	f death?			
24a. Was an autopsy performed? 1 Yes 2 No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25. Was case referred to medical examiner? 1 Yes 2 No No Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide Accident 5 See Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number or Ru	Unknown			
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28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Nu City or Town, State) 28g. Location (Street and Number or Rural Route Nu City or Town, State) 28g. Location (Street and Number or Rural Route Nu City or Town, State) 28g. Location (Street and Number or Rural Route Nu City or Town, State) 28g. Location (Street and Number or Rural Route Nu City or Town, State) 28g. Location (Street and Number or Rural Route Nu City or Town, State) 28g. Location (Street and Number or Rural Route Nu City or Town, State) 29g. Certifier 1 Xeertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29g. Signature and title of certifier 29g. Date signed (Month, Day, Year)				
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)	mber,			
Y 7 2 9 9 6 6 C(Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)				
5 # 5 129b, Signature and title of certifier 29c, License number 29d, Date signed (Month, Day, Year)	manner stated.			
Dao 65733 3/5/11				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
Mb A E. Mylt > Theet, BLICTON, DD 21921				
State Registrar NAR 0 8 2011 32. Registrar's Stanture 34. Registrar's Stanture 35. Registrar's Stanture 36. Registrar's Stanture 36. Registrar's Stanture 37. Registrar's Stanture 38. Registrar's Stanture 38. Registrar's Stanture 39. Registrar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			_ For	State of	Marylan	d / Depa	artment o	f Health	and N	lental Hyg	jiene		
			State Registrar			Cer	tificate o	f Death		F	Reg. No. 2	1.1	07221
	Physicia	n/	1. Decedent's Name (First, Middl	e, Last)	7	homa				2. Date of Dea Month		Year	3. Time of Death
	Medic	al	lyree	L		TOPAG				March		2011	7:14 PM
)	Examin	er	4a. Facility Name (if not institution	1/	per)	1	4b. City, Town	n, or Location	of Death	12	4c. County	of Death	C12
	Funeral		5. Social Security Number		. Age (In yrs. la	st birthday)	If Under 1 Ye		24 Hrs.	8. Date of Birth	29	9. Birth	place (State or Foreign
	Director		214-64-7477	6. Sex 7 1 M 2 □ F	53	Yrs.	Months Da	ys Hours	Min.	0971 P	Ĭ I 57	Cour	vatry) VA
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	he Ma or 28; noti	اقّا	10e. Street and Number				10f. Zip Cod	le			10g. Citizen of	What Cour	
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	teath tems er mu	Funeral Director	11. Marital Status	12. Was Deced			Vas Decedent of Yes, specify C	of Hispanic Ori	igin? (Spe	cify Yes or No-		e - Americ	
36	after or ", or camin	by	1 Never Married 2 Mar	rried 1 Tyes 2	2 V No		☐ Yes 2 😿			riioari, etc.,	Specify	ck, White,	etc.
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nd	ould be filed within 72 hours after death with the Maryland the Mental Hygiene. In Mental Hygiene. Marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	o Be	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	e (First, Middle, I	/laiden Surnam	e)	
yla	uld be file Mental narked c	입	HORACE THOMAS					MAR	Y C.	BOYKINS			
Maryland 21215-0036	इंड ज		19a. Informant's Name/Relations		_		-			l Route Number,		State, Zip (Code)
	and 2 s Health tem 27		DIANE N. DUCKE 20a. Method of Disposition	TT/DAUGHTE		<u>. </u>	W. MUL sition (Name of			BALTIMO Date	20c. Location	212:	
Baltimore,			1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other (State Co	emetery, crem	natory or other CREMATI	olace)	_				
ᄩ	permit. Page Department Important: I any injury o		21. Signature of Funeral Service	· · · · ·	/ UN-		. Name and Ad			3/12/11 MES A M	BALT]		F.H., INC.
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9/8	certificate be executed nding physician and use as the burial-transi	ושו	IF FEMALE:										
89 ×	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 🗌 Fetal	Ideath 3	Ectopic pregr	ancy				te of delive	•
Box	death the atte	/sic	1 Yes 2 No	4 ☐ Pregna 9 ☐ Unkno	ant at time of d wn	eath 5	Other (specify)			Mo	onth	Day Year
0	that the ined by the detacher		Part II. Other significant conditi	ons contributing to dea	ath but not resu	ulting in the u	nderlying cause	given in Part	I.	23e. Did to	pacco use cont	ribute to th	ne cause of death?
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ord	law requires nas been sig e 2 should be	Completed								24a. Was a	n 24b.	Were autor	psy findings available
ě		omp	11-27-121							autop: perfor	med?	death?	mpletion of cause of
<u>a</u>	sician: The certificate rector, pag	Be C	25. Was case referred to medical				26	. Place of Dea	ith (Check		2 No	1 🗌 Yes	2 E No
<u> </u>	nysici lis cel direc	To B	examine? 1 Yes 2 No	Hospital: 1 ☐ In	npatient 2 🛂	ER/Outpatien	t 3 □ DOA	Other: 4 🗌 No	ursing Ho	me 5 🗆 Reside	ence 6 🗆 Oth	er (Specify)
o i	ing Pi		27. Manner of Death 1 ■ Natural 5 □ Pendi	28a. Date of (Month,	f injury , <i>Day, Year)</i>	28b. Time of injury	l v	njury at /ork?	- 1	28d. Describe ho	w injury occurr	ed	
lo :	terding death tor A tor A the fu	Certificate:		igation				Yes 2					
Division of Vital Records,	or Att	Cert	4 ☐ Homicide determ		f Injury - At hor g, etc. (Specify)		et, factory, offi	ce]	28f. Location (St City or Town		er or Rural	Route Number,
ָ ב	spital nours neral filled	edical	29a, Certifier 1 Certifying	g Physician: To the bes	st of my knowle	edge, death o	ccured at the t	ime, date and	place, an	d due to the cau	se(s) and mann	er as state	d.
E	to the hospital or Attending Physician: within 24 hours aller death. To the Funeral Director After this certifica completed filled in by the funeral director, for	Med	(Check 2 ☐ Medical I	Examiner: On the basis g Nurse Practioner: To	of examination	and/or invest	igation, in my op	oinion, death o	ccurred at	the time, date an	d place, and du	e to the cal	use(s) and manner stated.
,	vithi To th		29b. Signature and title of certifie		7	1112		ense number			9d. Date signe		
			& Bugli	2/1/12	Unis	MO	U	006	155	55	March	17,	2011
			30. Name and address of person	who completed cause	death (Item		000	ng las	D. A	Jayo, M	D	-	
	Ct-		31. Date filed (Month, Day, Year)	1018 POS	jistrar's Signati	Empr	zency	De	oart	ment			•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07225 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 6, 2011 Rose E. Tully 4:20 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8820 Walther Blvd Apt 3318 Parkville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 □**X**F Hours 9/18/1921 MaryTand 212-12-5935 89 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8820 Walther Blvd U.S.A. Apt 3318 21234 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 X No Specify: Specify: White 3 ¥ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Dept Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unit F. Crossley Dorothea Hiltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5 Fountain Ridge Circle Parkville, Maryland 21234 David A. Chapline / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Dulaney Valley Mem. 3/12/2011 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Bladder Onset and Death Cancer disease or condition Month resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1type tervion 2√No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24a. Was an

Physician/ Medical Examiner Examine

and

attending physician for use as the burial

signed by the a d be detached f

has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Physician/Medical

þ

Completed

To Be

Certificate:

Medical

State

Registrar

IF FEMALE:

Hospital or Attending Physician: The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records,

Physician/

Medical

10a. State

Director

Funeral

by

Completed

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Examiner

Funeral

Director

other traumatic event,

permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once.

Mach 6th 0420

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

autopsy performed? Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25.	Was case reexaminer?	eferred to media	26
27.	Manner of I	Death	_

☐ Homicide

29a Certifier

29b.

Natural 5 Pending 2 Accident 3 Suicide

Investigation 6 Could not be determined

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

M

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifier	1 Certifying Physician: To the	best of my knowledge, death occured at th	ne time, date and place, and due	e to the cause(s) and manne	er as stated.
(Check	2 Medical Examiner: On the base	asis of examination and/or investigation, in my	y opinion, death occurred at the ti	time, date and place, and due	to the cause(s) and manner stated.
only one)	3 — Certifying Nurse Practioner	: To the best of my knowledge, death occurre	ed at the time, date and place, and	d due to the cause(s) and ma	nner as stated.
Signature	nd title of cortiflor	07- 1			

29c. License number DIBIT

29d. Date signed (Month, Day, Year) Mach 2011

21234

30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

8800 1+hu Wal

31. Date filed (Month, Day, Year) MAR 0 8 2011 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 1:00 p M David W. Vaught 2011 08 Medical 4a. Facility Name (if not institution, give street and,number) Examiner 4c. County of Death Baltimone osedale If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □**x**M 2 □ F Hours 230-44-5988 April 10 Country) Director ,1936 74 VA Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 3a or 28a-f sh t be notified MD Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a must 505 Old Home Road 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces Black, White, etc. 9 ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygbers. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Y Yes 2 □ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exa White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Paint 11th Warehouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Vaught Joan Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan A. Vaught /wife 505 Old Home Road Baltimore MD 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 😾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 3/8/11 Baltimore MD 21. Signature of Fun- al Servic License 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Anoxia Physician/ Medical resulting in death) Due to (or as a consequence of); Examiner trnes Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or linjury that initiated events in death), act Physician/Medical Examiner yocardial Infanction or Attending Physician: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last the attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown ate has been signed by the atte page 2 should be detached for Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? this certificate 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the I within 2 only one Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month, Day, Year)

N DHMH 17 Rev 7/2009

State Registrar 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201^{Year} Vakkalanka Radha Krishna March 3:19 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 □ F Months Days Hours May 18, 1955 Director 230-37-9227 55 India Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits must be notified 28a-f Marvland Montgomery Germantown 1 🗌 Yes 2 🗓 No ō 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 23a Funeral 18910 Porterfield Way 20874 United States items Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 9 Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced Specify: Asian Indian ed other than "natu event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Scientist of Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Seshagiri Rao Pulipaka Mahalakshmi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Achuta K. Vakkalanka /Wife 18910 Porterfield Way, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematorium, Inc. March ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Signature of Fun Service Sensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Inguette Darnio M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cardiac Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes I Director: After to in by the funers 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours after Funeral Dire leted filled in b Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the basis of my incurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the basis of my incurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOV 9901 Medical Ctr Dr Rockville, MD mehar. Fischatsion mD 31. Date filed (Month, Day, Year) State MAR 0 8 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 17 per inf., g913,03/24/20IIdhb

Amend Item 3 per dr., g913,03/20Pldtb

Amend Item 3 per dr., g913,03/20Pldtb For A State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 31, 2011 Unknown[™] January <u>James Wingate</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville 7221 Harford Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-48-0272 1 ☑ M 2 □ F 64 Jan 28, Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exerciper must be notified at Director 1 ☐ Yes 2 ☑ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 7221 Harford Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 No 11. Marital Status 14. Race - American Indian. 1XIYes 2 If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore unk unk. accounting clerk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Calvert Wingate William Wingate Vivian Burgesser 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Stricker - cousin 2230 Kentucky Ave; Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5₺Other (Specify) in state 21. Signature Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ca e (Final disease or con ilion resulting in death) Physician civita o condid /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 No certificate Division of Vital 1 □ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 DNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this filled in by the funeral 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 La Matural 5 Pending 1 □Yes 2 □ No 2 Accident investigation after death Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide thin 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52016 23 2011 Samara 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 650 Waiel Samara 200 33 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 0 8 2011 Jarka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., gg 13.03/07/2011 dnb and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ann Whitney М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Medical Prince George's Center Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, Year)

Jan. 17, 1914 9. Birthplace (State or Foreign Country) NJ Funeral 6. Sex 7. Age (In yrs. last birthday) Days 1 □ M 2 🖾 F Hours Min 97 Director 185-05-7355 Usual Residence of Decedent or 28a-f show within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 XYes 2 No MD Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3800 Lottsford Vista Road 20721 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0, ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: "natural", Completed 3 x Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) hould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important; If item 27 is marked o Frank Garnavich Eva Lubus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Garnavich (Nephew) 3435 Memphis Lane, Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 g permit. Page 1 and Department of H ö 1 X Burjar 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) Canton Cemetery 02-16-2011 Canton, MS 21. Sign ture of F, neral Service Lice ee 22. Name and Address of Facility Breeland Funeral Home 3304 S. Liberty St., Canton, Mississippi nu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each li x. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-trar that initiated events resulting in death) Last Due to (or as consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Dav Year 1 | Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Other: ပ္ 1 Tes 1 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
28c. 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death, To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical (29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certific 29d. Date signed (Month, Day, Year) February 4, 2011 M mpleted cause of death (Item 30. Name and address of person who 26a) (Type, Print)

State Registrar Month, Day, Yeaf

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** 6:45 PM 2011 Patsy R. Wallis /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALT (MORE N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1 □ M 2**X** F Virginia 1953 **Director** 217-62-3605 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Experiment mat be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21236 5118 Alberta Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chiropractor Nurses Aide 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarice J. Caudell ဂ Ralph B. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5118 Alberta Avenue Baltimore, Maryland 21236 Jimmy R. Wright, Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Cedar Hill Cemetery 03/10/11 Glen Burnie, Maryland MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor fromos 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CELL LUNG CANCER 6 MONTHS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any and in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> OBSTRUCTIVE PULMONARY DISEASE 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 2 No 1 ☐ Yes 2 **N**0 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 1 No Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE RICHARASON MO 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death March X011 Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) Sept. 27,1936 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 XM 2 □ F 216-32-4303 Yrs. 74 Pennsylvania Usual Residence of Decedent 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No N/A MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 1245 Armistead Way 21205 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 ☐ No If Yes, Give Year or Dates: 1956-60 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify. 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Manufacturing <u>Machinist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martha Fabian Raymond Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Georgia J. Ward (Wife) 1245 Armistead Way Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 3/7/2011 Baltimore, Maryland 21. Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland or(complications caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one can Immediate Cause (Final disease or condition resulting in death) wee. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? Yes 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 1 Tes Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) Manner of Death 28a. Date of Iniun 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Nature 2 Accident (Month, Day Injury M 1 🔲 Yes 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Box 68760, P.0. of Vital Records,

g physician and as the burial-tran attending physician The law requires that the death certificate be After this certificate has been signed by the atten funeral director, page 2 should be detached for a certificate has Physiclan: After this Division or Attending death. Director: 24 hours after (Funeral Direc ne Hospital n 24 Φ

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner and.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

29a. Certifier (check only

29b. Signature and title of certifler

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State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

completed/cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) MAR 08 Registrar

MERINA

ORIGINAL

4940 Eastern Avenue, Baltimore, MD, 21224

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 8:45 AM John G. Whitty Medical March 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Hospital Bel Air Harford If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. 1 M 2 - F Months Hours Director 78 Yrs 102-24-7185 May 22 New York Usual Residence of Decedent show train money of persons and a state of them 23a or 28a-f short raumatic event, the Medical Examiner must be notified at 10a. State 10b County Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Tes 2 No Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20 Box Hill South Parkway Unit 320 21009 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married should be filed within 72 hours after If Yes, Give Year or Dates. 951 1 ☐ Yes 2 ☑ No Specify: 3 ₩idowed 4 ☐ Divorced 5 Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) l Hygiene. other than "ı Elementary/Seconday (0-12) College (1-4 or 5+) **Janitorial** Janitorial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည John S. Whitty Sadie Bell Bevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr John J. Whitty /Son 139 Whitaker Avenue North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Mar 07 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 2011 21. Signature of Funeral Service Licensee M01442 22. Name and Address of Facility Cremation and Funeral Alternatives 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter undenying Cause (Disease or iinjury that initiated see or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery m800430 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 9 🗆 Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes Accident 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 40062765 of death (Item 23a) (Type, Print) pper Chesapeake Dr. Bel State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records.

Division of Vital

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amend #205666 Bernard and Department of Health and Mental Hygiene
amend #8 Per FH G914 4/15/2011 JH
Certificate of Death

Reg. N. 2 | | 1. Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death Physician/ 50 PM Month Year DAVID YOUNG 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13 Bi imie Hrunde lashinat If Unde Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. 01-071-1951 **Funeral** 1 1 M 2 □ F Months Hours Min. Director Yrs. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 4 No 10e, Street and Numbe ò 10f, Zip Code 10g. Citizen of What Country? Funeral 23a selle 6 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Wildowed 4 Divorced Specify: Completed Black 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Cousin 27 Department of Health Important: If item 27 any injury or other to once. sarne 20a. Method of Disposition 20 MesdowroidgeanMem.Par 07/2011 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility MASO N 67 908 KENNEdy WASHDC STNW 23a. Part 1. Eyer the decase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart follure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ ULMONARY disease or condition Medical resulting in death) Due to (or as a consequence of Examiner EREBRO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) HYPERTENSION The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERLIPIDEMIA Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page Yes 2 🗌 No Yes 2 🗆 N To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 100 Other: 1 Impatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: . Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif D6909 TARAK REDDY, MD .01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE, GLEN BURNIE, MD, REDDY 301 MD 31. Date filed (Month_Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 Day Physician/ 5/6 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death LOCK MONZ GONIEL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F Months Min. Director Usual Residence of Decedent or 28a-f show : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SELFEM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State moun 4 Donation 5 Other (Specify) Signature of Funeral Service License 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown ed by the P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2. N Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Division 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:49 PM Medical 01 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER N/A If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 6-25-195) **Funeral** 9. Birthplace (State or Foreign Months Hours Min Director 212-56-7542 MARYLAND Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If them 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be norified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD. N/A BALTIMORE 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1926 HOLLINS ST. 21223 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) <u>-10-</u> SANITATION BALTIMORE CITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HERMAN YOUNG ELIZABETH NURNETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MABLE YOUNG(SISTER IN LAW) 1926 HOLLINS ST. BALTIMORE, MARYLAND 21223 20a. Method of Disposition 1 Burial 2 Cren 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Cremation 3 - Removal from State 4 Donation ☐ Other (Specify) MT. ZION CEMETERY 3-10-2011 BALTIMORE, MARYLAND 21. Signature **NANTANOL** HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death

DAYS Physician/ SEPTICEMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day 2 🗌 No g Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🗙 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work' 2 🗌 No Accident Investigation 1 🗌 Yes Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medica 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) Schrenk MD P25541 MARCH 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATHERINE SCHRENK SOUTH GREENE ST. BALTIMORE, MD 31. Date filed (Month Day, Year) - • State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				State of Maryland	/ Department of Health on	•	•
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	and		Usual Residence of Decedent 10a. State 10b. County	10c. City. To	own or Location		10d. Inside City Limits
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ore	92 0		20a. Method of Disposition 1 ☐ Burial 2 Paremation 3 ☐	20b. Place ceme	e of Disposition (Name of etery, crematory or other place)		ocation - City or Town, State
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen		22. Name and Address of Facility	- Charach	E Euneral Homas PA
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н			23a. Par 1. Enter the disease, or ming shock, or heart failure. List only of Immediate Cause (Final	one cause of each line.	o not enter the mode of dying, such as car	diac or respiratory arrest,	Approximate Interval Between Onset and Death
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σ.	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit		Part II. Other significant conditions co	entributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
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ta	sician; The certificate h rector, page	a)	25. Was case referred to medical		26 Place of F	1 □ Yes 2 ® No Death (Check only one)	1 ☐ Yes 2 ☐ No
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Division	r Att ter de irecta n by t	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street as City or Town, State	nd Number or Rural Route Number, e)
Ω	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune			Tr.			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	iner: On the basis of examination	ge, death occurred at the time, date and pl and/or investigation, in my opinion, death o	ace, and due to the cause(securred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.	29c. License number	29d Da	ate signed (Month, Day, Year)
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	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	ed d	7 - 7.0011	1
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas	se Type or Pri			Indelible Inloartment of H		•		_	,
	•	For State Registrar	Otate of W	ai yiai k	•	ertificate of L		-	Reg. N	0011	07238
Physicia	n/	Decedent's Name (First, Middle, LEONARD	Last)			ZUCZIN		2. Date of De Month	D	ay Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, g	give street and number)			ZUSKIN 4b. City, Town, or	Location of Death	MARCH	04	c. County of Deat	03:00 P ^M
	_	GILCHRIST HOSP				TOWSON		_		BALTIMO	
Funeral Director		212-28-3685	5. Sex 1 M 2 □ F	e (In yrs. las	84 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 09/29/		9. Bird Co.	thplace (State or Foreign untry) MD
show d at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or I	_ocation					10d. Inside City Limits
Maryl 28a-f otifie	irec		IMORE	PI	KESVI						1 ☐ Yes 2 🛣 No
ath the	Funeral Director	10e. Street and Number 11 SLADE AVENUI	F #200			10f. Zip Code 21208			10g. C	Citizen of What Co	
items		11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	. 13	Was Decedent of Hi				14. Race - Ame	
s after or ral", or Examir	ed by	1 ☐ Never Married 2 🛛 Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 If Yes, Give Year or Dates.	No		1 ☐ Yes 2 🔀 No		, , , , , , , , , , , , , , , , , , , ,		Black, White Specify: WH	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highest	t grade completed)		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired)		king	16b.	Kind of Business	
within giene. ier tha	e Cor	Elementary/Seconday (0-12)	College (1-4 or 5	ō+)	ine.		INTANT			ACCO	UNTING
should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, La: CHARLES	st)	7	USKIN	,	18. Mother's Nan	ne (First, Middle,	Maider	n Surname) TURE	7
ind Me ind Me s mark umatic		19a. Informant's Name/Relationship	p (Type, Print)			iling Address (Street a		ral Route Numbe	er, City o		
nd 2 st lealth a m 27 is ner tra		LINDA ZUSKIN /	WIFE			SLADE AV	ENUE, #2	09, PIKE	ESVI	LLE, MD	21208
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire x7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		ce	metery, cr	position (Name of ematory or other place CREMATION,		7/2011		Location - City or AMPSTEAD	
permit. Departn Importa any inju		21. Signature of Funeral Service Lic	Muga	_		22. Name and Addres					, INC. , MD 21208
hysician/ Medical		23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):									Approximate Interval Between Onset and Death
Examiner	<u>.</u>	Sequentially list conditions,	b. Ad	taic	Le	deme	utra				years.
ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	a conseque	ence of):							
executed an and rial-transit	_	that initiated events resulting in death) Last	ence of):			-			<u> </u>		
physician the buria	dica		d								
attrending attending for use as	Physician/Medical	1 Live Birth 2 Fetal death 3 Ectopic pregnancy						23d. Date of de Month	livery Day Year		
been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the									
been si	eted		<u> </u>					24a. Was			robably 4 Unknown topsy findings available
siciant. The law is certificate has be lirector, page 2 s	Completed				-			autor	osy ormed?	prior to death?	completion of cause of
s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 \square E	R/Outpati	ent 3 DOA Othe	er:		donos	6 Y Other (Spec	(6) 11 - 20 - 1 - 2
iding Fin ith. : After thi e funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of inju (Month, Day	ry 2	28b. Time injury	of 28c. Injury	/ at	28d. Describe h			ify) Histopice,
or the Ospital or Attentioning Prysician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e Place of Inju		ne, farm, s	treet, factory, office		28f. Location (S City or Tow			ral Route Number,
Hospita 24 hours Funeral eted filler	Medical	(Check 2 - Medical Exa		xamination	and/or inve	estigation, in my opinio	on, death occurred a	at the time, date a	and plac	e, and due to the	cause(s) and manner stated
within To the comple	Σ	only one) 3 Li Certifying N 29b. Signature and title of certifier	Nurse Practioner: To the	pest of my	knowledge	29c. License		ce, and due to the		ate signed (Month	
		> popolt	^	イア		D7	1040		3	>/5/1,	
61		30. Name and address of person when AP ATIAT	no completed cause of d			,		A - 10%		, ,	0.000

Registrar DHMH 17 Rev 7/2009

State

ARATHI ŁUMAR

31. Date filed (Month, Day, Year)

MAR 0 8 2011

ST, SULTE GIOT BALTIMORE MD 21204

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **JOAN** LIEBERT **ZACHARY** Mayreth 6. 2011 4:00P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson 11 Chiara Court Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🛶 F Months Days Hours Min 12⁷73⁷1936 434-56-4677 ou i stranna Director 74 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Chiara Court 21204 USA "natural", or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No Š Black, White, etc. 1
Never Married 2
Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 3XX Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working other than life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked and Mental ဂ Joseph Liebert Gertrude Kollin permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 Chiara Court Towson, Maryland 21204 Venetia Frances Zachary 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 。□ Burial 2 🕱 Cremation 3 🗆 Removal from State GreenMount Crematory 03/08/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funeral 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be examiner? မ 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation 24 hours after deatl Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the bast of my knowledge, or all commend at the line, date and place, and due to the cause(s) and manner stated. 2 | 3 | distithe time, date and place, and due to the 29b. Signature and title of certifie D 2653 4 30. Name and address of person who completed cause of death (texh 23a) (Type, Print) (duson mp #105 Siste 120 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiens State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LIONEL Month 20 / AYOTTE JR ARTHUR 05:44 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia 5. Social Security Numbe If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 Modern **Funeral** 8. Date of Birth 1 XM 2 □ F Days Hours 007-28-9098 Months 78 Director Maine Usual Residence of Decedent ıral", or items 23a or 28a-f shov I Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Columbia Howard Maryland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 21044 10g. Citizen of What Country? Funeral 5488 Cedar Lane B-3 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces'
1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc δ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify "natural" 3 Divorced 4 Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work doine doining , life. DO NOT use retired) Data Processor and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Almeida Hebert Lionel A. Ayotte, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 5488 Cedar Lane B-3, Columbia, Maryland 21044 Anita J. Ayotte- Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Wash. Crem. 03/10/2011 Laurel, Maryland 22. Name and Address of Facility Witzke Funeral Home, Inc. f Funeral Service License e 21. Signature 5555 Twin Knolls Rd, Columbia, Maryland 21045 M01283 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Amyotrophic Lateral Sclerosis Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to ior as a consequence on Examin or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has this certificate 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending iniury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗌 29b. Signature and itte of crifier D648 29d. Date signed (Month, Day, Year March 6 2011 Ian

✓ DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Sav. Year)

who completed cause of death (Item 23a) (Type, Print)

/an

Bar

Howard County Gen. Hosp.

HC CoH5 Cedar Lane, Columbia, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 2011 Sally Mae Baldwin 8:45 ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 3205 Lawnview Avenue Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min. 1 M 2 W Country) Virginia Hours Director 216-54-5502 6 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside, City Limits Director MD BALTIMORE 1 Yes 2 No N/A 10e. Street and Number 10g. Citizen of What Country? Funeral 3205 Lawnview Avenue USA 21213 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian. þ 1 Never Married 2 M Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 Y No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Baltimore City Housekeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Freddie Chambers Sally Kate Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bevian David - Daughter 1617 Gorsuch Avenue Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Green Mount Cemetery 3/14/2011 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Furieral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1 Enter the disease, or complications that caused shock, or head failure. List only one cause on each line. Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Physician/ Medical Onset and Death disease or condition resulting in death) weeks maria Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-transi ause (Disease of linjur) that initiated events Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes s been signed by the s should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate of completed filled in by the funeral director, pag ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural ☐ Accident Investigation 1 Yes 2 No 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Egger St IANA HEFFNER CRNP 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Honth Feb. 27. Shirley Рм Gladys Brown 7:50 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TA 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 02-25-1934 1 M 2 x Director 219-30**-**6960 VA Usual Residence of Decedent or 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9104 Lilac Park 20723 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify. White Completed 3 X Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mortgage Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be to Department of Health and Menta Important: If item 27 is marked Gerald Bookout Gladys Joy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Brown - son 1100 Topridge Court, Gambrills, MD 21054 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 03-03-2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of uneral Service Liden Inc, 7250 Wash. Blvd, Elkridge, MD 21075 MMP, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Due to (r as a consequence of): ysiciani disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed neum onia signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No Yes 2 N funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ည 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury accurred 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No Accident Investigation within 24 hours after deal To the Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) medical hospitalist 060390 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel HDEEB Annupolis MO 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene?

			1 - State Registrar	Cert	ificate of E	Death	,	Reg. No.		0/243
	Physicia		1. Decedent's Name (First, Middle, Last) Lillian Blevins				2. Date of Dea Month	Day \	/ear	3. Time of Death
	Medio Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of		11.15 1
	Francis		Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	thday)	Ba.	ltimore If Under 24 Hrs	8. Date of Birt		V/A	In a finite of Familia
	Funeral Director		218-44-6915 1□M2対 65		Months Days	Hours Min.		1945	Count Mar	lace (State or Foreign ry) yland
Maryland 28a-f show otifled at	ne Maryland or 28a-f show notified at	Director	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town 10c, Street and Number	n or Loca	Brookly	n Park		40-08		0d. Inside City Limits 1 Yes 2 □ No
	s 23a o	Funeral	5323 Wasena Avenue			21225	-	10g. Citizen of Wh		States
9600	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	ted by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates.	lf `	as Decedent of Hi Yes, specify Cubar	n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Black, Specify:	White, e	etc.
Maryland 21215-0036	within 72 ho giene. er than "nat , the Medica	Be Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5	(Give kii life. DO	ent's Usual Occupa nd of work done d NOT use retired) sabled		rking	16b. Kind of Busi Une r		
yland	ild be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Unknown				me (First, Middle, i known			
~	の井の中							r, City or Town, Stat		
Baltimore,	Page 1 and лепt of Heal ant: If item 3 ury or other		20a. Method of Disposition 20b. Place of cemeter 1 □XBurial 2 □ Cremation 3 □ Removal from State cemeter	f Disposi ry, crema	tion (Name of htory or other place of Faith	e)	Date	n Park, N	ity or Tov	
Baitir	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Garde 21. Signature of Funeral Service Licensee	22.	Name and Addres	s of Facility H	übbard F	uneral Ho imore, Ma	me,	Inc.
H			23a. Part 1 Inter the disease, or complications that caused the death. Do n shoot, or heart failure. List only one cause on each line.	_						Approximate Interval Between
	h sician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Colon (Whiter a. Due to (or as a consequence of the condition control of the condition condition control of the condition condition control of the condition cond	of):						Onset and Death
	od sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):					+	
	trincate be executed ng physician and as the burial-transit		that initiated events c Due to (or as a consequence or cons	of):						
8/60	certificate be anding physicia use as the bur	Medical	d						_	
SOX OF	e death certi the attendin	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (spec <i>if</i> y)	/		23d. Date of Month		ry Day Year
.,	res that tr signed by	ρ	Part II. Other significant conditions contributing to death but not resulting Ir	n the und	derlying cause give	en in Part I.		bacco use contribu		e cause of death?
Vital Records,	e law requi e has been ige 2 should	Completed					24a. Was a autop	an 24b. Wei	re autop:	sy findings available inpletion of cause of
T E	ian: In	Be C	25. Was case referred to medical examiner?		26. Pla	ce of Death (Che	1 🗌 Yes ck only one)	2 ☑ No 1 □	Yes 2	2 🗆 No
IN OT VII	to the hospital or Attending Physician: The law requires that the death cent within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	유	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of injury 28b. Ti		28c. Injury work?	at		ence 6 Other (s	- pati Specify)	ent hospice
DIVISION OF	tal or Atter rs after dea al Director ed in by the	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, stree			28f. Location (St City or Town	treet and Number c n, State)	r Rural F	Route Number,
:	e rospi 24 hou e Funer leted fill	Medical	29a. Certifier (Check (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, conduction on the basis of examination and/or only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, conduction on the basis of examination and/or only one)	r investig	ation, in my opinior	n, death occurred	at the time, date ar	nd place, and due to	the caus	se(s) and manner stated.
	o th withir сощ	<	29b. Signature and title of certifier NS Ryapama M · 0 ·	age, co.	29c. License		1 2	29d. Date signed (A	Aonth, Da	
	51		30. Name and address of person who completed cause of death (Item 23a) (T N . S・Raya Pa KSe , M・D・ 283 S Smith	ype, Prir	s- 203 -	Raltime	ore, MD:	21209		
	Stat Registra	•	31. Date filed (Month, Day, Year) 22. Registrar's Signature	back	2		·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mantheut 6.08 201 William Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death BALTIMOIZ WASHINGTON MEDICAL CE BURNIE ANNE ARUNIDE . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 6, 1927 **Funeral** 9. Birthplace (State or Foreign Months Hours 1 🗶 M 2 🗆 F Mary Land Director 216-20-9564 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🄀 No Baltimore <u> Anne Arundel</u> <u>Maryland</u> 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21226 1122 Hilltop Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. SALILA A Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give 21215-0036 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A U.S. Navy Sailor Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Betz, Sr. Katherine Seymor William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Hilltop Road Baltimore, Maryland 21226 <u>Elsie B. Lins (Companion)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 03/11/11 4 Donation 5 Other (Specify) Glen Haven Mem. Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPSIS Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Unknown 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne of Death Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number D 45149 W. 2011 10x e and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital drive 20161 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#23a, per PHYS, 6913, 379, 20 III, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2 20°11 5:20 рм Samuel Burwell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey House Baltimore na If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F (Month, Day, -1938 Director 246-60-9172 N.C. Usual Residence of Decedent pernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD na Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16 Mt Royal Avenue #712 21202 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 X Never Married 2 Married Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fannie Edwards ပ William Burwell 19a. Informant's Name/Relationship (Type, Print) Devoted 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 Peggy White-Friend 1623 Northqate Road Balto, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2x Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2-25-2011 Greenmount Balto, MD March East F/H Signature of Funeral Service Licensee 22. Name and Address of Facility Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death

Jan 2011 Physician/ disease or condition resulting in death) Non Small cell lung CA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death Yes been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown icate has been s r, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed?/ Yes 2 No this certificate 2 No 1 Ves Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 No ၉ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Matural Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director; of completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29d. Date signed (Month, Day, Year) 12011 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address o HORK 32. Registrar's Signature 31. Date filed (Month, Day, State MAR 09 Registrar

Samue

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM# 205, perfff, G914, 4/4/2011, WS

State of Maryland / Department of Health and Mental Hygien [2] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ENNE MA 1) (= O M Medical 4a. Facility Name (if not Institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4303 Miami Place N/A Baltimore 7. Age (In yrs. last birthday) 63 yrs. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. 213-46-4741 1 🗆 M 2 😿 F (Month, Day, Year) Hours Country) Director /13/48 MD Usual Residence of Decedent 28a-f shov with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 XYes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 4303 Miami Place 21207 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 K Married 1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 No Specify. 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced Completed Year or Dates American 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
House Wife 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) Self College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lindsey Washington Annie Rowlette 19a. Informant's Name/Relationship (Type, Print) Husband Meliuse L. Bennett, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 4303 Miami Place, Balt., MD 21207 of Health a or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If it any injury or of once. 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest $\frac{3}{2}$ ۷ą Owings Mills,MD 4 Donation 5 Other (Specify) 21. Signature of Fun ral Service License 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd,Balt.,MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d, Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\sum \) Yes 2 \(\overline{\ ō Month Year Day detached Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has I leted filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Tyes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ larch 658 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 13 Bo- Scci-15 1timore Itimore Hospital If Under Year If Under 24 Hrs. 8. Date of Birth 9/Birthplace (State or Foreign Country) (Av Y An A **Funeral** 1 M 2 🗆 Min. Director 5 20-72-107 Usual Residence of Decedent 28a-f shov 10a. State 10b. Count r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 17 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced ack Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam 19a. Informant's Name/Relationship (Type, Pt 19b. Mailing Address (Street and Number or Rural Route Number, City or ar toward 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location permit. Page 1 a Department of H Important: If ite injury or 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 4 Donation 5 Other (Specify) -12-2011 21. Signature of Funeral Service Licensee 1955 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 5 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 cate has been signed by the attending propage 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 25. Was case referred to medical examiner? the funeral director, æ 26. Place of Death (Check only one) 2 No Hospital Other: ျင 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 66108 6,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Elizabeth Benvengi 12:00 PM March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7022 Conley Street Dundalk 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Day, Year) 19,1946 Director 216-48-2311 Maryland 64 July Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21224 USA 7022 Conley Street or items hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc. 9 1 Never Married 2 XMarried Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates White 'natural", Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 7 years Housewife Own Home and Mental Hygiel is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) pe Hannah Ann Delanev Edward Joseph Delaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Sebastian Benvengi Husband 7022 Conley Street, Dundalk, Maryland 21224 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State March 10, 1 X Burial 2 Cremation 3 Removal from State injury or Sacred Heart of Jesus Cem Dundalk, Maryland 4 Donation 5 Other (Specify) 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, or complications that caused the death point enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ asmic disease or condition resulting in death) month Medical Due to fir as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Year be detached by the signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MORAD Powser

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are pegible. 072 1,9

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:30 AM 2011 Cichan 6, Vivian A. March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bultimore Genesis Multimedical Center TOWSON 8. Date of Birth (Month, Day, Year) 12-14-1928 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Yrs 82 Director Pennsyl vania 170-24-6106 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neture!", or Items 23a or 28a-f ehow any injury or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 3030 Arizona Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. by Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore County School System Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Fisher Amelia Kendter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10319 Waverly Woods Drive Ellicott City, MD 21042 Mrs. Christine Cichan - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 03-10-2011 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Viak 23a. Part1. Enter the discase, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart if pure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Advanced Chronic Obstructive Pulmonary Disease years /Medical Due to (or as a consequence of) Examiner Pulmonary Fibrosis years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Congestive Heart Failure years attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Atherosclerotic Cardiovascular Disease Physician/Medical years IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 12 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 3 DOA Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Certification: Injury at Work? 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a Nurse Practitioners 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Michelle E. Kalender, CRNP march 8, 2011 R097104 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle E. Kalendek Genesis Multimedical Center 7700 York Rd. Towson, MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 2011 Barke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 2011 7:39 A M Conley, Jr. R. George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore 708 Shelley Road If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Yea 1 XM 2 □ F 83 Director 128-18-7011 Time Usual Residence of Decedent items 23a or 28a-f shov ier must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Tes 2 X No Baltimore Towson MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21286 708 Shelley Road 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian "natural", or item ledical Examiner n 11. Marital Status Armed Forces?

1 XYes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify. White 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Labor Relations Personnel Director other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked oth Margaret Mary O'Reilly ည George R. Conley, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 708 Shelley Rd. Towson, MD. 21204 Margaret A. Conley/ Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Dulanev Valley Mem. 3-11-11 Timonium, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Funeral ervice Licensee 1050 York Rd. Towson. MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Durth Immediate Cause (Final Physician/ disease or condition resulting in death) eme Medical Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Unknown funeral director, page 2 should be detached 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 XNo certificate | 1 ☐ Yes 2 🔯 No the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospita Other: 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1_DNatural 5 \square Pending 1 Tyes 2 🗌 No Accident Suicide Investigation after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert arch tem 23a) (Type, Print) Road IIMONIUM Jall 32. Regist Date filed (Month, Day, Year) State MAR 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25tate of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Stephen W. Clarke 02 4:29 03 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Date of Birth (Month, Day, 9. Birthplace (State or Foreign 1 X M 2 D F Days Hours Min. Year Trinidad Director 128-463-795 59 09 1951 Usual Residence of Decedent shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 815 Thayer Ave 20910 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked or ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Cecil Clarke Elaine Watley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen W. Clark/Son 1316 Fenwick Ln #619 Silver Spring, MD 20910 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. 03/10/11 Alexandria, VA any in 22. Name and Address of Facility Marshall-March Funeral Home 21, Signature of Funeral Service Licenses 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as conditions that caused the death. Do not enter the mode of dying, such as conditions are shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a cons uence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 No Unknown 9 Unknown Part II. Other signif pditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No မ 1 🗌 Yes 1**XX**Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one and title of certifler 29b. Signatur 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nasreen M. Kango, MD 7701 Carroll Ave MD 20912 Takoma Park,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 9 201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2011 arr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Center Baltimore MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 3/24/1952 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min. 214-58-7158 1 □ M 2 🗘 F 58 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Madical Examiner must be notified at 1. Yes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5403 Ready Avenue 21218 MD "natural", or items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X☐ No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Assistant 12 Clinic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Withers Willette ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau once. Dana Carr 5307 Walther Ave. Balto. MD 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk 3/12/2011 Baltimore Co 22. Name and Address of Facility Phillip A Weatherford FS PA 2431 E. Oliver St. Balto. MD 21213 Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (of as a consequence of): **Examiner** 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 1 ☐ Yes 2 (1 Ne 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 | Yes 2 | No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death.
neral Director: Aff 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0070076 M-h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walthas Doch Date filed (Month, Day, Year) State MAR 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH,G913,3/14/2011,WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Michael Joseph Deets Physician/ March 2 201^{Year} 2:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5114 W. Runningbrook Road Howard Columbia Social Security Number 8. Date of Birt 9-12-1965 S. (Month, Bay, Year) 5-5 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MO 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 - F Days 45 **Director** 218-94-9587 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1925 St. Paul Street USA 21218 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc þ 1 X Never Married 2 ☐ Married ☐ Yes 2 XNo Yes, Give 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates, 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Director Transportation Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Joanne Lolkes 17. Father's Name (First, Middle, Last) Dan Deets 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5114 W. Runningbrook Road, Columbia, Maryland 21045 Mary J. Deets - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Park 03/07/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donaţion 5 ☐ Other (Specify) Marriottsville, MD Funeral Service Lie 22. Name and Address of Facility Witzke Funeral Home, Inc. 21. Signature M01283 5555 Twin Knolls Road, Columbia, Maryland 21045 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Mother's 2 **N**0 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence nours after death.

neral Director: After the filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Tes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Gertifying Nurse Practioner: To the Sest of my knowledge 29d. Date signed (Month, Day, Year) 29b. Signature and til of certifier 2 41139 March 3 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Clement B. Knight, M.D. 10710 Charter Drive Suite GO20 Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Maleka Darby-Clark Feb 26. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11219-B Heron Place Waldorf Charles 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Hours 577-82-1432 Jume^{th,} f3, 1968 42 Washington DC Director Yrs Usual Residence of Decedent 28a-f shov 10b. County aţ 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1
▼ Yes 2 □ No Waldorf Marvland Charles ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 11219-B Heron Place 20603 United States death 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\tilde{\text{M}} \) Yes 2 \(\tilde{\text{P}} \) \(\tilde{\text{P}} \) 88 \(\text{P} \) Yes, Give Year or Dates. \(1998 \) 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ō þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: B1ack Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany injury or other traumatic event, the Meany injury or other traumatic and injures. DC Metro Transit Elementary/Seconday (0-12) College (1-4 or 5+) Clerk System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Darby Lula Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 11219-B Heron Place, Waldorf, Maryland 20603 Derano Chuvalo Clark/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🖾 Removal from State cemetery, crematory or other place March 4, 4 Donation 5 Other (Specify) Quantico National Triangle, Virginia 2011 21. Signature of Funeral Service Licens 22. Name and Address of FacilitiRobert G Mason Funeral Home Inc Donald R. Gray 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of nset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ic Medical Due to (or as a consequence of): Examiner Secuentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ō Pregnant at time of death Month Day Year be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Be Completed 1 🗌 Yes page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Certificate: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I funeral 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Ďescribe how injury occurred Natural 5 - Pending 1 🗆 Yes 2 🗆 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 126250

MERCANTILE LANE, LARGO, L.D. 20774

Registrar
DHMH 17 Rev 7/2009

State

MATILDA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1221

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ March 4, 2011 10:10 p^M Charlotte Elizabeth Engel Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Summitt Park Nursing Home Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours 12/12/1914 Maryland Director 217-05-3296 96 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Me Ical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director MD 1 ☐ Yes 2 🛱 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1502 Frederick Road 21228 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked of William Kroner Nettie Rollins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 sl Health a mportant: If item 27 Harry G. Engel / Son 415 Lexington Way, Littlestown, PA 17340 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of ö 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 3/9/2011 Woodlawn, Maryland 1. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) nding physician and use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day the. P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iours after death.

neral Director: Aff
filled in by the fur Accident
Suicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted f (Check Certifying Nurse Practioner: To the best knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated le of certifier 29d. Date signed (Month. Day, Year) of person who completed cause of death (Item 23a) (Type, Print) Luick Rd. Catonyville 21228 1009 31. Date filed (Month, Day State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 201°1 9:05 P M Physician/ March William Harry Frizzell Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Westminster Carroll Hospice (Dove House) Date o (Month, Da 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Day, Days 1**XX**M 2 □ F Months Hours 1935 MD 75 Nov Director <u>218-32-2267</u> Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 🛣 No Mt. Airy Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States Funeral 21771 7483 Watersville Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after 1 ☐ Yes 2XX No Specify Specify: White Maryland 21215-0036 If Yes Give 3 ₩ Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Westinghouse Welder 10th 18. Mother's Name (First, Middle, Maiden Surname) Be traumatic event, 17. Father's Name (First, Middle, Last) Hazel V. Haines ျ Truman A. Fizzell Page 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3646 Joycin Ct. Ellicott City, MD 21042 Health a Terry Hamby (Daughter) other 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If it any injury or o ₽ 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 3/12/2011 Airy, MD Mt. Prospect Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory,
1212 W. Old Liberty Rd. Winfield, MD 2178 permit. any in 21. Signature of Euneral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition wmo GUQY Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Month Year in the past 12 months? Yes 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing o death but not resulting in the underlying cause given in Part I ò 1 X Yes 2 No 3 Probably 4 Unknown aryuk CONCOY Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No မ this 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No М within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title q 03/09 HOUSE AUE, FREDERICK, Md. 2170) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TULL W. HASSEN 801 IRFAN 31. Date filed (Month, 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death . 2<u>011</u> Physician/ Month March 7 Marjorie Grevembera 3:32 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Martins Home Baltimore Catonsville . Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 434-58-3882 1 □ M 2 😾 F Days Hours 87 2/14/1924 Director Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD Baltimore Catonsville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 601 Maiden Choice Lane 21228 USA ıral", or items 2 Examiner mus 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", White 3 Widowed 4 X Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Durrucar Mabel Glotz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Judith O. Harris / Granddaughter 23 Sunset Drive, Severna Park, Maryland 21146 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot rial 2 💢 Cremation 3 🗌 Removal from State Donation 5 Other (Specify) Bayview Crematory 3/8/2011 Baltimore, Maryland of Funera Service Licensee 21. Sign 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (*/s a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi signed by the attending physician and dbe detached for use as the burner of that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation ☐ Accider 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 21649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar bandam

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31. Date filed (Month, Day, Year)

AUG

WILKENS

BALTIMURE.

Karan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 9914 4-27-11 vt 24a per verb. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Damien Carlos Miller II 2. Date of Death 3. Time of Death Physician/ Month 13:05 PM march 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai B. Cer HOSPITA Bultimore 8 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **K** M 2 □ F Hours Min. (Month, Day, Year) Country) 15A 73 Brunson Director Usual Residence of Decedent fshow 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No 23a or 28a-1 MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3318 Kessler Ct. <u> 21227</u> or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Je filed wn. Hal Hygiene. Ser than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/Aand Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Damien Carlos Miller Gabriel Brunson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Chandra Miller(Grandmother 33<u>18 Kessler Ct.</u> Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 03/09/11 Baltimore. Signature of Funeral Service Licenses 30sepHddHsofBHown Jr. Funeral Home PA 2140 N. Fulton Ave., BAltimore, MD cam 21217 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Pmysicianz EXTTEME prema disease or condition resulting in death) Medical Examiner Due to (or as a conseque ce of) Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Pulmonary Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 No 1 Yes 2 L 9 Unknown ed by the a detached i 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 🗌 Yes 2 No 3 🗌 Probably 4 🗍 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA this Date of injury (Month, Day, Year) 27. Manner of Death 28a 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗀 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0040362 MEDICA 2401 W. BEIVEDETE AVE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O'BriEn MD Baltimore, 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav **Physician** Hoback 530AM 2 /Medical 4a, Facility Name (If not institution, give street and number)
Let WSCS K-i dlwood Min nov
SGA Celi I Anemul 4b. City, Town, or Location of Death 4c. County of Death Examiner Millersville NID tone If Under 1 Year | If Under 24 Hr Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Social Security Number **Funeral** Months Days Hours 1 M 2 X F North Carolina 212-28-8038 80 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f shov Example to the contilled at 1 □Yes 2 TNo Director Glen Burnie Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 7132 Baltimore -Annapolis Boulevard 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 KMarried Baltimore, Maryland 21215-0036 1 Tyes 2XXXVo Specify þ 3 Widowed 4 Divorced White Completed er than "natur 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Johnson George Emerson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1700 Frederick Rd., Catonsville, MD 21228 Ann Ring - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 03-09-2011 Elkridge, Martland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service License MMP, Inc, 7250 Wash Blvd., Elkridge, MD 21075 Part 1. I here the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Neart Failure **Physician** years disease or condition resulting in death) /Medical Due to (or as consequence of): **Examiner** Sequentially list conditions sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) ronic Due to (or as a consequence of) attending physician Physician/Medical as asi 23c. If yes, outcome of pregnancy

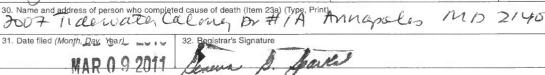
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Hoursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: 24 hours a within 2.

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie



Clarkmp

DHMH 17 Rev 1/2001

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29d. Date signed (Month, Day, Year)

8/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 12:22 PM Sr. Hartsock Paul Lee 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Towson Manor Care - Ruxton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Date or Day, (Month, Day, **Funeral** Age (In vrs. last birthday) Maryland Months Days Min. Year 1 XX M 2 □ F 81 Director 213-26-1779 January Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he mattered at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21222 8117 Del Haven Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. X Yes 2 No Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 X Widowed 4 Divorced Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Fire Department 8 yr's Communications Lineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Myrtle Walker Hardley Hartsock Mary Vernon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4620 Greencove Circle Baltimore, Maryland 21219 Paul L. Hartsock, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 12,2011 Oak Lawn Cemetery Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Baltimore, Maryland 21214 5305 Harford Rd. Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician, Pertensio Medical resulting in death) (or as a consequence of): Due t Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🔀 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 ☒ No After this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3029 Dundalk Ave, Dundalk, MD 21222

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:56 pm 201 Medical rman la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore arl imonium Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Yea 0 **Director** Usual Residence of Decedent items 23a or 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 🗌 Yes 2 No timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Black. White, etc Armed Forces 0 1 Never Married 2 Married 1 Yes : 2 No 72 hours after 21215-0036 1 Yes 2 No Black Specify: "natural", 3 Widowed 4 ☐ Divorced Completed Year or Dates. 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Motor laryland Ò Be permit. Page 1 and 2 should be filed in Department of Health and Mental High Important: If item 27 is marked other any injury or other traumatic event. Maryland 18. Mother's Name (First, Middle, Maiden Surname Father's Name (First, Middle, Last) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Horne Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State andalls town 2-201 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Millan 0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

To the Funeral Director: After this certificate has been signed by the attending physician and or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 2 No Records, 1 Yes 24b. Were autopsy findings available 24a Was an autopsy performed? Yes 2 X prior to completion of cause of death? 2 🗌 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 **X** No HOSPICE မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 \square Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check X Certifying Nurse Practioners to the best of my knowledge, death at the time, date and plane, and rh 29d. Date signed (Wonth, Day, Year) 29c. License number 29b. Signature and title of 011 n who completed cause of death (Item 23a) (Type, Print) 30. Name and address of TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP 31. Date filed (Month, Day, Ye State 9 Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

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	_	State Registrar				C	ertificate of	Death	Re	g. Nor-	07263	
hysicia /Medica		1. Decedent's Name Diane El		^{ast)} Henderson					2. Date of Death Month February	Day Year 27, 2011	3. Time of Death 8:30 P M	
Examine		4a. Facility Name (I Woodside 5. Social Security N 212-64-2	Center	Sex 7. A	ge (In yrs. I 56	<i>last birthda</i> Yrs.	Silver	r Location of Death Spring If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dea		
rector		Usual Residence of	f Decedent						July 1,	1954		
f show	tor	10a. State 10b. County MD Montgomery				10c. City, Town or Location College Park					10d. Inside City Limits 1 □ Yes 2X No	
3a or 28a st be noti	al Director	10e. Street and Number 4506 Hartwick Rd				10f. Zip Code 20090			10g. Citizen of What Country? USA		country?	
o,"la	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	unk ied 2 Married 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	nnk	S. 10	3. Was Decedent of H If Yes, specify Cub	an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: W		
than "nature ne Medical E	Completed	(Spec Elementary/Seco unk	15. Decedent's Ecify only highest gondary (0-12)		5+)	16a. Dec (Gir life	cedent's Usual Occup ve kind of work done b. DO NOT use retire	pation unk during most of work d)	king 1	6b. Kind of Business	s/Industry unk	
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n 27 is ma ier trauma		19a. Informant's Na Rhea G	,	(Type. Print) guardian		80	oiling Address <i>(Street</i> D5 Brights	eat Rd; I				
ant: If iten ury or oth		20a. Method of Disp 1 ☐ Burial 2 b 4 ☐ Donation	□ Cremation 3 l	□Removal from State			position (<i>Name</i> of rematory or other pla			0c. Location - City o	r Town, State	
Import any inj once.		21. Signature of Euneral Service Sicensee Board Service Signature of Euneral Service Sicensee Board Service Signature of Euneral Service Sicensee Board 655 W. Baltimore St; Baltimore, MD 21201										
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an signed build be deta	ed by Phys	Description of the state of the							5 40			
ficate has be	Completed									prior to death? No 1 □Ye		
ter this certil	n: To Be	25. Was case refer examiner? 1 Yes 2 27. Manner of Deat	No	Hospital: 1 Inpat	ury	ER/Outpat 28b. Time Injur		ner: 4 Nursing H	ome 5 Resider 28d. Describe how	nce 6 Other (Sp	pecify)	
Director: Af	Certification:	1 ☐ Natural 2	5 Pending investigation 6 Could not determine	be 28e. Place of Ir	20/0	ome, farm,	street, factory, office	A M 1 □ Yes 2 ☑ No A // eet, factory, office 28f. Location (Street and Number or Rural Followin, State → 100 / 200)				
e Funeral letely filled	Medical Ce	29a. Certifier (Check only one)	1 Certifying F	Physician: To the bes aminer: On the basis and manners	of examina	wledge, de	eath occurred at the t	ime, date and place opinion, death occu	e, and due to the ca	ause(s) and manner ate and place, and di	as stated.	
To the		29b. Signature and	title of certifier	\cap		es en t	29c. Licen			d. Date signed (Mo.	nth, Day, Year)	
	}	30. Name and addr	ress of person who	o completed cause of	death (Item	n 23a) (Typ	e, Print) 52 4	Hans	Ersbur	7 5	90K	
Stat Registra	_	31. Date filed (Mon	nth, Day, Year)	32/Regis	trar's Signa	ture	arke	P		- 10	-/-	

7. Age (In yrs. last birthday) 78 Yrs. Social Security Number 8. Date of Birth (Month, Day, Year, **Funeral** Days 236-70-5065 1 □ M 2 🔀 F 28, Feb Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, The Medical Expression in ust be notfilled at Directo Severna Park Anne Arundel MD 10f. Zip Code 10e. Street and Number 21146 18 Marbury Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No à 3 ☐ Widowed 4 ☒ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be America Prado Jorge Labeco ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11 Robinson Rd; Severna Park, Maryland 21146 Victoria Cain - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Euneral Service License Rona Ld. S 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 2 - No P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed autopsy performed' 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of injury (Month, Day, Year) 28b. Time of Injury 27. Manne of Death Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 Tyes 2 🗆 No 2 Accident reral Director: / 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

6. Sex

Neusa L. Hardy

18 Marbury Rd

Physician

/Medical

Examiner

 $\overset{\text{Day}}{2}4$, $2\overset{\text{Year}}{1}$ 8:00 Рм 4c. County of Death Anne Arundel 9. Birthplace (State or Foreign Country Brazil 10d. Inside City Limits 1 ☐ Yes 2 TNo 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc white 16b. Kind of Business/Industry healthcare 20c. Location - City or Town, State Approximate Interval Between Onset and Death year 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cadse of death? 2 1 No 5 ☐ Residence 6 ☐ Other (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar DHMH 17 Rev 1/2001

24 hours a

Medical

State

4 Homicide

29b. Signature and title of certifie

Date filed (Month, Day,

29a. Certifier (Check only one

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Severna Park

2. Date of Death

February

1932

USA

2

11-01472 Joseph Hickman

7963

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Озеритискитан	1- For State Registrar	Certificate of	f Death	Reg. N	2011	0/200
Physician/	Decedent's Name (First, Middle,Last)			Date of Death Month Day	y Year	3. Time of Death 0857 hrs
Medical Examiner	GOSEPH HICKMAN		4b. City, Town, or Location of Dea	February 22,	2011 4c. County of Death	0857 118
	 Facility Name (if not institution, give street and number 1615 Cole Street 	lu i	to county of Death			
Funeral	5. Social Security Number 6. Sex 7.7	Age (In yrs. last birthday)	If Under 1 Year If Under 24H		M/DD/YYYY) 9. Birth Foreign	
Director	216-50-2776 1×M 2 F	64 yrs	Months Days Hours M	Oct 9, 1	946 Cou	intry)Maryland
ku w	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locat	tion			10d. Inside City Limits
8 . n	MD	Baltimor	:e			1 X Yes 2 No
the Maryland is or 28a-f sh orified at once	10e, Street and Number		10f. Zip Code	10g. C	itizen of What Coun	try?
th the Maryland 23a or 28a-f sho notified at once.	1615 Cole Street		21223		USA	District District
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. fem 27 is marked other than "natural", or items 23a or 23a-f she traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 12. Was Decede 1 Never Married 2 Married Armed Force	s?If Y	as Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Puer		14. Race - Americ White, etc.	can Indian, Black,
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215-0036 te filed within 72 hours tal Hygiene. ked other than "naturent, the Medical Exami	Elementary/Secondary (0-12) College (1-4 o unk unk	,	orer		construc	tion
5-00; lied with Hygiene Jother ti the Mea	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	en Surname)	·
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Complé	Joseph Douglas Hickman			Mae Johnso		
MD 21 d 2 should lith and Me n 27 is ma numatic ev	19a. Informant's Name/Relationship (Type, Print) Gloria Montgomery - si:		ng Address (Street and Number o 09 Chamberlain F		-	
e, MI l and 2 s Health a item 27	20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery,	Date 200	c. Location - City or 1	Town, State
MOCE Pages 1 ent of F int: If i	1 Burial 2 Cremation 3 Removal from 4 Donation 5 X Other Specify: in state	State	uter place)			
Baltimore, permit. Pages I an Department of Hee Important: If ite	21. Single of Frank Service Licensee Ronald S. W. e. Di	rector 22.1		State Anato	•	0.1.0.0.1
Physician	23a. Part I. Enter the disease or complications that cause	_ 1 (655 W. Baltimore the mode of dying, such as cardiac	St; Balti or respiratory arrest, s	more, MD	21201 Approximate Interval
Medical	failure. List only one cause on each line.		rdiovascular Dis		3	Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a condition)		1410740003321 221	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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ted Insit Examine	(Disease or injury that initiated	preguence of):				
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iox 68760, eath certificate be executed a attending physician and for use as the burial - transit /sician/Medical Ex	■ MENDED AMENDED 2. IF FEMALE: 23c. If yes, outcome the second of	3a,pt.II,27	per me g913 3-11	-11 vt		
ficate be g physicist the burn's	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the 1 Live birth	come of pregnancy	etal death 3 Ectopic preg		23d. Date of delivery Month D	ay Year
b. Box 687 the death certification by the attending puched for use as the Physician/	past 12 months?	at time of death	ther (Specify)	, j		,
. Bo	Part II. Other significant conditions contributing to de		underlying cause given in Part I.	23e Did tobaco	co use contribute to t	he cause of death?
P.O. es that the igned by be detach	Chronic Alcohol Abuse	att bat not resulting at the	discriying caase given in Facts.			ably 4 🗸 Unknown
Records, The law requires ficate has been signage 2 should be Completed	OHI OHIZO TILOUTUS TIS GO			24a. Was an autopsy		topsy findings available ompletion of cause of
Division of Vital Records, talor Attending Physician: The law requir rs after death. al Director: After this certificate has been seled in by the funeral director, page 2 should be prification: To Be Completed				performed		_
ician: The lician: The lician: Certificate lector, page	25. Was case referred to medical examiner?		26.Place of Death (Chec	k only one)		lay-and
F Vit Physici or this o	1 Yes 2 No	itient 2 ER/Outpatient		sing Home 5 Resi	idence 6 🗸 Other:	Scene
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/islor r Attenc r Attenc ter death irector: n by the ficatio	2 Accident Investigation 3 Suicide 6 Could not be	Injury - At home, farm, stre	eet, factory, office building, etc.			ral Route Number, City
Division o ospital or Attending hours after death. Increal Director: After y filled in by the fune Certification:	4 Homicide determined (Specify)			or Town, State)		
	29a. Certifier 1 Certifying Physician: To the best of one) 2 Medical Examiner: On the basis of e					
To the Ho within 24 To the Fu complete!	and manner state 29b. Signature and title of certifier		29c. License number		d. Date signed (Mon	
	Mla Brand Me	}	O.C.M.E.	Fe	ebruary 23, 201	1
	30. Name and address of person who completed cause of		N D-15	MD 04000		
			V. Baltimore Street, Baltim	nore, MD 21223		
State Registra	44 B A A BO44 K	trar's Signature				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 2011 ROBERT G. HELMS 7:05 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8316 HILLENDALE ROAD BALTIMORE HILLENDALE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🖳 M 2 🗆 F Hours 2/10/1958 MARYLAND Director Yrs 216-72-5986 items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at by Funeral Director MD BALTIMORE HILLENDALE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8316 HILLENDALE ROAD USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married 2 X No ö Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates "natural", Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PROPERTY MANAGEMENT than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene is marked other tha MAINTENANCE SUPERVISOR 10TH GRADE Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or over 18. Mother's Name (First, Middle, Maiden Surname) ഉ GEORGE HELMS JOAN DWYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICKI L. HELMS/WIFE 8316 HILLENDALE ROAD HILLENDALE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State METRO CREMATORY, INC. 3/9/2011 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO217 RAVEN BLVD. TOWSON. 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (o) as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? ₽4a. Was an Jas autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🕍 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the Funeral Director: After the pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) N N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Medical Name (if not institution, give street and number) 4a. Facility Examiner 4b. City. Town, or Location of Death 4c. County of Death C 11 more 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 F Months Director and idence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County Na State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗹 Yes 2 □ No more 10e. Street and Number 10g, Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give à 1

Never Married 2

Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Divorced 4 Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) re of Funeral Service Licensee 21. Signa eral Itom 23a. Part . Ent ./ he diseas ./ r complications ti. t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death alioblastona Physician/ 0 years Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying ng physician and as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last led by the attending physician detached for use as the burial Physician/Medical requires that the death certificate be 03/66 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Yes 2 the Hospital or Attending Physician: The thin 24 hours after death.

the Funeral Director: After this certificate ! 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospie & မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending (en JA Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) March 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Richey Hospice Baltimore MD Stand, Ford MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Fer DVR G913 3/09/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month February 26 201^{Yea} LINDA JOHNSON unknown™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A BALTIMORE FUTURE CARE-CANTON . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2XXF Days (Month, Day Months Min. 58 **Director** MARYLAND 220-64-0666 'n. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND BALTIMORE N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1300 S. ELLWOOD AVENUE 21224 U.S.A. hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1XXNever Married 2 Married ş Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give 3 Widowed 4 Divorced Specify: BLACK Completed and Mental Hygiene.
is marked other than "naturanmatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DISABLED N/A 0vrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 be 1 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. RICHARD JOHNSON MARY ROWE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Ellerslie Ave., Baltimore, Maryland 21218 Molene Martin/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify BAYVIEW CREMATORY 03-10-2011 BALTIMORE, MARYLAND 21. Signature of Fune all ervice Licen 2. Name and Address of Facility
MILLERS METROPOLITAN CHAPEL
1639 N. BROADWAY, BALTIMORE Part 1. Enter the disease shock, or heart failure. Li se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Metas Ph sician/ Medical resulting in death) Due to (or as a consequence of Examiner ASWD Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 2 No 3 Probably 4 nknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 this certificate 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manyler of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sig re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09 and address of person who completed cause of death (Item 23a) (Type, Print) NARENDER PAI BHARAJ 2 MARKET PLACE DUNDALK MD 21222 31. Date filed (Month, Day, Year) 32. Registrar's Sanatur MAR 0 7 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:08A.[™] Marie Johns March 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1701 Wickes Avenue Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Ye 8/18/1964 1 🗆 M 2 🖵 F Months Hours Min. Director 219-94-0055 46 Virginia Usual Residence of Decedent or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of the ritan "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of the ritan "natural", or items be notified at amportant intony or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director XXX Yes 2 No N/AMaryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Wickes Ave 21030 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 🏋 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sylvia Sue Wiles Kager Lee Johns.Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myr1 Shore/Friend 1701 Wickes Ave., Baltimore, Maryland, 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) Meadowridge Memorial |3/8/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner VIZA Section fally list no officers if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami the burial-transi Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 \square Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

State Registrar

only one)

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as statted.

29c. License number D 2 6 2 5 6

29d. Date signed (Month, Day, Year)

CHICE LY BALTIMOREMO 2/228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 12:05 PM Ne MARCH 01 Medical Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** N/A If Unde 7. Age (In yrs. last birthday) 63 vrs If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 9 10 7 4 9 Country 213-52-2709 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director or 28a-f sl notified MD N/A Baltimore 1 K Yes 2 □ No 10f. Zip Code 21213 10e, Street and Number ems 23a or r must be r ٥ 10g. Citizen of What Country? Funeral 3847 Lyndale Ave USA er than "natural", or items; the Medical Examiner mus 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, d Forces rmed Fo Black, White, etc. þ 1 Never Married 2 Married 1 \times Yes 2 \square No If Yes, Give 1 965 – 67 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify: Completed 3 - Widowed 4 - Divorced Amer. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Owner Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Grocery Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Ethel Mae Joyner Randolph Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Joyner/Wife 3847 Lyndale Ave, Balt., MD 21213 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place)
Bayview Crematory 1 Burial 2 X Cremation 3 Removal from State 3/11/11 Balt., MD 4 Donation 5 Other (Specify) 22. Name and Address of Facilit Hari P. 21. Signature Funeral Service License Close F.S,PA ,MD 21206-5105 5126 Belair Rd, Balt. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death METASTATIC BLADDER CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or) signed by the attending physician and deed be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 Hospital or Attending Physician: The la 24 hours after death. Euneral Director: After this certificate h performed? Yes 2 N 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 🗌 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 \square Pending X Natural work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined า 24 hours a e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 25582

State Registrar 30. Name and address 6f

SUFFREDIM

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla State of Maryla State of Per di	ind / Department Certificate	96 Health and e of Death	Mental Hygie		07271	
	Physici		1. Decedent's Name (First, Middle, Last) PEQV FIRST			2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examir		4a Facility Name (If not institution, give street and number) Courtland Garden	s Ra	Town, or Location of Dea	nw		more	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yr</i> 200 - 18 - 5629 1 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M	rs. last birthday) If Under Months Months	Days Hours Min		ar) 9. Birth	place (State or Foreign ntry)	
	vith the Maryland or 28e-f show	ctor	10a. State 10b. County 10c. 0	City, Town or Location	rile		1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	th with the 23a or 28 ust be no	ral Director	8 Dequville C+ Ap	+2A 101. Zip	21208	10g.	Citizen of What Cour	ntry?	
920	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28e-f show the Medicel Exandrations Lectivitied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes, Sive Year or Dates:	U.S. 13. Was Deced If Yes, spec	lent of Hispanic Origin? leify Cuban, Mexican, Pue 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: B		
Maryland 21215-0036	be filed within 72 hours ital Hygiene. d other than "natural", event, I'm Medicel Ex-	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT us	rk done during most of w	orking 16b	. Kind of Business/In	dustry A'C	
yland 2	should be filed within of Mental Hygiene. marked other than imatic event, I'm III.	To Be Co	17. Father's Name (First, Middle, Last) Allen Vales	1 101716		ame (First, Middle, Maid	den Sumame)		
	Health ar tem 27 is other treu		19a. Informant's Name/Relationship (Type, Print) May gareth J. Smith 20a. Method of Disposition 1 print 2 Cremation 3 Removal from State	19b. Mailing Address Place of Disposition (Nam cemetery, crematory or ot	(Street and Number or I	+2A, Ba	ty or Town, State, Zip. 14 MBG Location - City or To	MD 21208	
Baltimore,	permit. Pages Department of Importent: If i any njury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Euleral Service Licensee	Poutus 22. Name and HOO	d Address of Facility	7/2011 E	Funera E, Balto	Re, MO L Home M) 21207	
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	Examiner	dical Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
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rds, P.O.	juires that the d n signed by the ald be detached	d by Ph	Part II. Other significant conditions contributing to death but not re	esulting in the underlying ca	ause given in Part I.	23e. Did tobac	co use contribute to to	he cause of death?	
Division of Vital Records,	The law ate has b page 2 s	Complete	Caddio rymelly.			24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of	
of Vita	Physicien: T this certificat ral director, pa	To Be		□ ER/Outpatient 3 □ DO	A Other: 4 Xh ursing	eath (Check only one) Home 5 Residence		(y)	
/ision	ding h. After fune	Certification:	27. Manner of Ceath Salary 1 2 Accident Solution of Could not be determined determined 1 28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At the could not be determined 1	t home, farm, street, factory,	8c. Injury at / Work? 1 Yes 2 No		t and Number or Rura	al Route Number,	
Div	pitel or burs afte erel Dir filled in l		29a. Certifier 1 Certifying Physicien: To the best of my k	crity)	at the time, date and pla	City or Town, S	e(s) and manner as s	stated.	
	To the Hos within 24 hd To the Fun completely	Medical	(Check only 2 Medicel Exeminer: On the basis of examinand manner stated. 29b. Signature and title of certifier		License number		Date signed (Month.		
			30. Name and address of person who completed cause of death (It	iem 23a) (Type, Print)	44817	, (narch O	1.200/	
9	Sta	te_	Sunilp Rajani, M.D., 2434 W. 31. Date filed (Month, Day, Year) 32 Registrar's Sig	Belvedere Av	ve.,Baltimo	re, MD 2121	.5		
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loseph Leo Kenned		Maryland / Departm	nent of Health and Menta cate of Death		2011 072	272
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)	Joseph Leo Kei Seph Kenne		2. Date of Death Month Day February 28, 2	Year 3. Time of De 1410 hr	
	4a. Facility Name (if not institution, give stre 6208 Old Middletown Road	eet and number)	4b. City, Town, or Location of D Jefferson		c. County of Death Frederick	
Funeral Director	5. Social Security Number 5 7 0 - 8 8 - 3 4 3 4	7. Age (In yrs. last bi		4Hrs. 8. Date of Birth (MN 10 / 16 / 1	952 Seirthplace (State Foreign Country) M	
faryland 28a-f shaw any lat once. ector	Usual Residence of Decedent 10a, State	ick 10c. City, Town		Letown	10d. Inside C	
the Maryland sa ur 28a-f sh ptified at one	10e. Street and Number 6208 Old Midd	letown Road	10f. Zip Code 21769	10g. Ci	tizen of What Country? USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked uther than "natural", ur items 23a nr 28a-f than or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married 1 1 3 Widowed 4 X Divorced 1 1 or	Was Decedent Ever in U.S. Armed Forces? Yes 2 No s, Glive Yeer 969-71 ates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No specify:	erto Rican, etc.)	14. Race - American Indian, Bla White, etc. Specify: White	ack,
5-0036 ed within 72 hours stygiene. the Medical Exam	12	ghest grade completed) 16a. College (1-4 or 5+) 2	Decedent's Usual Occupation (Give kind during most of working life. DO NOT use Salesman		Kind of Business/Industry Real Estate	
1215-C be filed v antal Hygi arked nth vent, the	17. Father's Name (First, Middle, Last) Leo Joseph				Smith	
e, MD 21 1 and 2 should Health and Me item 27 is ma traumatic ev	19a. Informani's Name/Relationship (Type, Paul M. Kennedy		b. Mailing Address (Street and Number 2958 Grundsau Cl			051
Baltimore, MI pernit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum	20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other Specify:	emoval from State crema	of Disposition (Name of cemetery, tory or other place)	/5/2011 W	Location - City or Town, State Moodbine, MD	
	21. Signature of Funeral Service Licensee	mundum	PU BOX 141	3, Bailimo	re, MDZ 1203	
Physician x z xaminer	failure. List only one cause on each lir Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cisease or injury that initiated	ne.	herosclerotic Card		Between O	nset and
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ox 68 eath certi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	Pregnant at time of death	2 Fetal death 3 Ectopic pre		ld. Date of delivery Month Day	Year
P.C es that igned l	Part II. Other significant conditions cont Liver Disease	ributing to death but not resultin	g in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of do	
Division of Vital Records, tall or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the fineral director, page 2 should be artification: To Be Completed				24a. Was an autopsy performed?	24b. Were autopsy findings prior to completion of codeath? 1 Yes 2	ause of
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Division of the Bospital or Attending hin 24 hours after death. The Funeral Director: Aft upletely filled in by the final incal Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f (Specify)	arm, street, factory, office building, etc.	28f. Location (Street or Town, State)	and Number or Rural Route Num	ber, City
Divis To the Hospital or A within 24 hours after To the Runeral Dire completely filled in b	one) 2 Medical Examiner: On to and		ath occurred at the time, date and place, investigation, in my opinion, death occurred.	ed at the time, date and pl	ace, and due to the cause(s)	
	29b. Signature and title of certifier COV OF H	allan	29c. License number O.C.M.E.	3545	Date signed (Month, Day, Year) rch 2, 2011	
	30. Name and address of person who compl Carol Allan, MD Assistant M	edical Examiner 900	W. Baltimore Street, Baltimore,	MD 21223		
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	arled			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Mar			n and Mental Hyg	giene 011 07273
			Registrar 1. Decedent's Name (First, Middle, Last)		tificate of Death	2. Date of Dea	th 3. Time of Death
	Physicia Medic	al .	FRANCES P.	KMI	ECIAK	MARC	has Zoll 400 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) Seasons Hospice Northwest H	Josni tal	4b. City, Town, or Locatio	allstown	4c. County of Death Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (Ir	n yrs. last birthday)		der 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		220-18-8439 1 M X F Usual Residence of Decedent	83 Yrs.	World S Days Hours	March 1	
	land show d at	ţō	10a. State 10b. County 10	Oc. City, Town or Lo			10d. Inside City Limits
	e Mary r 28a-f notifie	Direc	Md. Baltimore		Dundalk T10f, Zip Code		1 ☐ Yes 2 🔀 No 10g. Citizen of What Country?
	with th	Funeral Director	6603 Maple Ave.		2122		USA
336	ould be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" are must be notified at imatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates.	, 11	Vas Decedent of Hispanic C Yes, specify Cuban, Mexic Yes 2 X No Speci	can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	72 hours n "natur ledical I	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done during mo	ost of working	16b. Kind of Business Industry
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and	be filed antal Hy ced oth c event	To Be	17. Father's Name (First, Middle, Last) Abner Underhill		. 18. Mo	other's Name (First, Middle, I Lillian Ly	
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	nd 2 st ealth a n 27 is		George Kmieciak Jr. Son	660	3 Maple Ave.	Dundalk, Md	. 21222
lore	Page 1 alment of Hannent of Hannent of Hannent If itel		1 🔲 Burial 2 😾 Cremation 3 🔲 Removal from State		natory or other place)	March 8,	20c. Location - City or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent ye	_	Crematory Name and Address of Fac		Baltimore, Maryland
ñ	Dep Imp any any	12	John (Harri Mo	1176	Connelly Fun 7110 Sollers	neral Home Of Point Road,	Dundalk, P.A. Dundalk, Md. 21222
			23a. Part 1. Enter the disease, or complications that caused the shock or heart failure. List only one cause on each line.	e death. Do not ente	er the mode of dying, such a	as cardiac or respiratory arr	est, Approximate Interval Between Onset and Death
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	Examiner	r e	Sequentially list conditions, b	oppositioned of:			
	ted J Insit	Examiner	if any, leading to immediate Due to (or as a concass). Enter of control of the c	onsequence or).			
	ate be executed ohysician and the burial-transit	al Exa	that initiated events C. Due to (or as a co	onsequence of):			
200	physic the bu	edical	d				
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ 1 ☐ Live Birt	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P.O.	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause given in Pa	art I. 23e. Did to	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Records,	Physician: The law rec this certificate has bee al director, page 2 sho	Completed					
/ita	rsician s certifi lirector	To Be	25. Was case referred to medical examiner? 1 Yes 2 M No Hospital: 1 Inpatient	t 2 ER/Outpatier		Death (Check only one) Nursing Home 5 Resid	tence 6 Cother (Special)
of	ng Phy fter this ineral c		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Y	28b. Time of	28c. Injury at work?	28d. Describe h	ow injury occurred
Division of Vital	pital or Attending I ours after death. eral Director: After filled in by the funer	Certificate:	2 Accident Investigation	- At home, farm, str Specify)	M 1 ☐ Yes 2 eet, factory, office		street and Number or Rural Route Number, in, State)
۵	spital c		29a. Certifier 1 Certifying Physician: To the best of my	y knowledge, death (occured at the time, date ar	nd place, and due to the car	use(s) and manner as stated.
	To the Hospital within 24 hours a To the Funeral C completed filled	Medical	only one) 3 Certifying Nurse Practioner. To the be		death occurred at the time, d	date and place, and due to the	
	ට දැද් ට ග් අද්ද		29b. Signature and title of certifier	This	29c. License numbe		29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of deat	th (Item 23a) (Type, F	Print)	Black C	March 7, 2011
	Sta	te	31. Date filed (Month, Day, Year) 82. Registrar's	s Signature	14 NA	13(000 1	att ov accor
	Registra	ar	MAR 0 9 2011 Person	A. Back	4		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 Day Month 2:40 PM 2011 Johannah Lawson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City Baltimore <u>Levindale Hebrew Geriatic</u> 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, Days 1 M 2 X F Country)
Maryland Months **Director** 10/28/1928 214-26-8852 82 Usual Residence of Decedent 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 10c. City, Town or Location 1 🗆 Yes 2 🔀 No Kingsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 11714 Bellvue Avenue 21087 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 2 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Elizabeth Gertrude Hirsch George William Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st nt of Health a :: If item 27 is 11714 Bellvue Avenue - Kingsville, Maryland Ursula Lawson (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ò Important: I any injury o 4 Donation 5 Other (Specify) 03/03/2011 Timonium, Maryland Dulaney Valley Mem. 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee <u> 11750 Belair Road - Kingsville, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiae Physician/ disease or condition resulting in death) 30 min Medical Due to (or as a consequence of): Examiner cardiovaseular disease Atherosel Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an page 2 autopsy performed? Yes 2 X No certificate of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural iniury 5 Pending work?
1 Yes 2 No Division 24 hours after death. Funeral Director: At Accident Investigation completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053928 02/26/2011 SURALYA BELZUM, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W, BELVEDERE 2434 AVENUE, BALTIMORE MD-21215 31. Date filed (Month, Day, Year) State MAR 09 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GLENWOOD GORDON LOWMAN, JR. Month 4.05 PM MARUT Medical 2011 0 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GOOD SAMARITAN HUSPITAL N/A TIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign **Ã** M 2 □ F Days 218-28-6106 Country) Maryland 77 Hours May 17 Day 1933 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho of Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Sylvan Way 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. Korea 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Institution Banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Glenwood Gordon Lowman, Sr. Dorothy Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lita Ann Lowman (Wife) 507 Sylvan Way, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💆 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Glen Haven Memorial Park March 9, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any in McCully-Polyniak Funeral Home, P.A. Kevin E Ecker 22. Name and Address of Facility 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition CONGESTIVE GEART Medical Examiner resulting in death) Due to (or as a consequence of) EVERE ADR TIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) The law requires that the death certificate be executed g physician and as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? performed? Yes 2 No Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate h 1 Yes completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 No 1 Yes Other: Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title 29d. Date signed (Month, Day, Year) ATTOMDING PHYSICIAN MARCH 00062239 05 2011 DR MAW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00,40 KMD 212391 SAMARITAN BOXECU AND GOOD HOSD1792

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** OL: LOAM March 04 2011 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes
5. Social Security Number Baltimore, MI If Under 1 Year If Under 24 Hrs. Hospital 9. Birthplace (State or Foreign MD 8. Date of Birth Month, Day 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 1 □ M 2 12 F Days 218-28-5798 Usual Residence of Decedent Yrs. Director 0 10a State 10b. County 10c. Pity, Town or Location 10d. Inside City Limits 28a-f show th and Mental Hygene.
7 is marked other than "natural", or items 23a or 28a-f shov fraumatic event, the Medical Exeminer must be notified at 1 Pres 2 □ No Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar ant: If item 27 is Department of Health Important: If item 27 any Injury or other tronce. MAID 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee nES, JR. FUNERAL Suc. PA. BAI to Ma Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final int Arction **Physician** Myocardial hours disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events reculting in death), act Physician/Medical Examiner the burial-tran resulting in death) Last Due to (or as a consequence of): for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 9 Unknown completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this After 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 **M**No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. March 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 S. Caton Ave, Baltimore, MD ilbermint F. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ewis

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 07277 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Richard Physician/ Dacey Lilley, Jr. Month рм 3:35 Medical March 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Cheasapeake Hospital Bel Air Harford 5. Social Security Number
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, Year)

 Months
 Days
 Hours
 Min.
 (Month, Day, Year)
 0 1 / 1 3 / 1 9 4 8
 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F 217-50-6830 63 Country) Director Usual Residence of Decedent 28a-f shov 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ams 23a or 28a-f sh r must be notified a MD Harford Bel Air 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Briarcliff Lane 21014 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Xyes 2 NoAir
If Yes, GiveForce
Year or Dates. 968 – Black, White, etc. Completed by 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: White 3 Widowed 4 Divorced er than "natur the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Master Electrician Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F 7 is marked of Richard D. Lilley Louise Yianna Kis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Lynn F. Lilley / Wife 106 Briarcliff Lane, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Important: If ite any injury or ot once. Date 1 Burial 2 XCremation 3 Removal from State Final Journey Crem. 3/9/2011 4 Donation 5 Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licensee Porota Marshal 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore., 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ HNOXIC encephalogathy disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner cardiac Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence or been signed by the attending physician and should be detached for use as the burial-transit multiorgan that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ lardiomyopath 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ್ತಿ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionars to the basis of my knowledge, Seath occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of oer D63420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1041 ZUBAIR KHARALIMD 500 UGGER CHESAPEAUE DRIVE BELAIR, MD 21014 State Registrar

✓ DHMH 17 Rev 7/2009

201

LICHARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARCH Helen Lewis 1-50 AM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Glen Burnie AnneArundel Co. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F 0 1975 1925 218-18-2414 Director 86 Maryland Usual Residence of Decedent show 10a. State 10b. County should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits Anne Arundel MD 1 Yes 2 No Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7822 Freetown Rd. 21060 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baftimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3₺ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation Bairea More ducty (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than "I Food Service Regional Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Department of Ed. Cafe Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ပ Leonard Spencer Eleanore Marie Garrett and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Irene Giles(cousin) 387 Broadleaf Ct., Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 03/14/11 Baltimore, MD 21. Signature of Funeral Service Licenses ²Josephorg of Febrown Jr. 2140 N. Fulton Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DAYS Sequentially list conditions if any leading to immediate any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (bries a nonsequence by Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Dav Yea Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsv certificate Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation after deat the Funeral Directory filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 ho

To the Function (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) nol-en D0061219 07, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar HARVINDER

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

ORIGINAL

ARORA

SNGH

BWMC HOSPITAL GLENBURNIE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAR 2216 M 201 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland Medic BALTIMURE N/A If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Jan 3 Day 945 Country) Maryland 219-40-5261 **Director** 66 Usual Residence of Decedent 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 124 W. Franklin Street Apt. 603 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 Divorced 4 Divorced Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Service Associate 7th Grade Funeral Homes Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever ၉ <u>Eddie Mason</u> Vondelier Gurry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 W. Franklin Street Apt. 603 Baltimore, Maryland 21201 Vondelier Mason - Mother Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lansdowne, Maryland 3/12/2011 Zion Cemetery Signature of Funeral Service License 22. Name and Address of Facility Chatman-Harris Funeral 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Par 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart jeilure. List only one cause on each line. mmediate Cause inal disease or condition resulting in death) Onset and Death Physician/ CARDIO MYO! ATH) a. 1000 ISCHEMIC Medical Due to (or as a consequence of): Examiner NFLUENZ Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ည 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, doubt continued at the time, date and place, and due to the cause(s) and manner as stated. (Check id at the time, date and place, and due to the cause(s) and mainler as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) \mathcal{O} , M P25615 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENS ST BALTIMORE las 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 31. Date file (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #1Per PHY ,6,17&18 Per FH G913 3/21/2011 JH State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M03/03/2011 Lucille Meredith 12:10 P M Lucille Mary Meredith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens Assisted Living Columbia Howard Security 1487 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Days Hours Min (Month, Day, Year) 08/25/1919 91 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD Howard Columbia 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21045 U.S.A. 7110 Minstrel Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 X Widowed 4 □ Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Own Home Homemaker Be 17. Father's Name (First, Middle, Last)
Earnest Callegary 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Debousier Alice DeBussieres 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel Meredith (Son) 10208 Stafford Lane Ellicott <u>City, MD 21042</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Gien Haven Memorial Park 4 Donation 5 Other (Specify) 3-8-2011 Glen Burnie, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Witzke Funeral
5555 Twin Knoll Homes, s Rd. Part 1. Enter the alsease, of co shock, or heart failure. List only opplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Interval Between Immediate Cause (Final Onset and Death
10 Years Pnysician disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Pregnant at time of death 5 Other (specify) Month Day Year ed by the a g Unknown g Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Congestive Heart Failure 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:
4 Nursing Home 5 Residence 6 X Other (Specify) Living 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XXNatural injury 5 Pending work? 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29b. Signature and title of certifier ည 29c. License numbe 29d. Date signed (Month. Day, Year) mD March 4, 2011 D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Parkway #301 Harry Li Columbia, Maryland 21045 31. Date filed (Month, Day Year) State Registrar 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

amend item 30 per dyr g913 3-9-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Meye 8:16 PM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death timore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 🗆 F (Month, Day, Months Hours Min. 213-62-12 08 59 Director Mary Tand Sept be filed within /2 1100000.

Anntal Hygiene.

arked other than "natural", or items 23a or 28a-f show arked other than "natural", or items 23a or 28a-f show arked other than "natural". Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1428 Woodall Street 21230 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Water Plant Operator and Mental Hygien Water Plant permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles A. Meyers Frances R. Gorecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Meyers wife 1428 Woodall Street Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State Holv Cross Cemetery March 11, 2011 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. Avenue Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to it as a consequence of): Examiner 10 m40 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit lerot that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Sessent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **№** No 은 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🖳 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) Emergency Depart husician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barnes 3001 S Hanover Street Baltimore, Md. 21225 31. Date filed (Month. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ Day Marlena Ε. 2011 9:25 PM McNu1tv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7709 Princess Place Pasadena Anne Arundel 5. Social Security Number 8. Date of Birth
Jan. 16, 1935 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Funeral Days 1 □ M 2 □XF Hours Mary Land Jan. Director 220-30-0358 76 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ី No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7709 Princess Place 21122 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. or 1 Never Married 2 Married ☐ Yes 2 🗓 No Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 XWidowed 4 ☐ Divorced Specify: Year or Dates White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) than " Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker is marked other Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 0 Walter Stein Anna Geissler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or any Marlena C. Lloyd (Daughter) 7709 Princess Place Pasadena. Marvland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. 03/08/2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P. 3204 Mountain Road Pasadena, Mary 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ADENOCARCINOMA Medical resulting in death) Due to (or as a consequence of) Examiner ANEMIA WEFKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consequence of and -transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 2 No been signed by the should be detached 1 ☐ Yes 2 ■ 9 ☐ Unknown a Hinknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 Hospital or Attending Physician: The l 24 hours after death. death? performed? Yes 2 👪 No 25. Was case referred to medica Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 29a, Certifier 💻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Pwithin 24 29b. Signature and title of certifier

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State Registrar RAYGAN HARRIS-LOFFON 244 MAGOTHY ROAD PASADENA
31. Date filed (Month, Day, Year)

32. Registrar's Signature

MAR 0 9 2011 Chronia A. Market

lress of person who completed cause of death (Item 23a) (Type, Print)

D0064565

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Month 9:45 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Genter ot Baltimore)niversity MD 7. Age (In yrs. last birthday) 53 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 K Days **Director** Indiana 316-72-3425 Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕅 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 315 Somerset Drive 21122 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) N 'A Elementary/Seconday (0-12) Doctor's Office Veterinary Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mingle Elsie June Smith Lloyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Somerset Drive Pasadena, Maryland 21122 Justin C. McCurdy (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 03/08/2011 Glen Burnie, Maryland Atlantic Cremation 22 Name and Address of Facility, McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Peritoneal adenocarcinoma _. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter onderlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Pregnant at time of death Day s been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas certificate ha rector, page 2 performed? Yes 2 No 2 🗌 No 1 Tes Hospital or Attending Physician: 25. Was case referred to medical examiner? **Division of Vital** funeral director, Be 26. Place of Death (Check only one) 2 🗹 No Hospital Other: 1 🗌 Yes |@ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending nours after death. neral Director: Aff d filled in by the ful Accident 1 Tes Investigation Suicide Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completed filled is Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 To the F 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 1871818336 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV

DHMH 17 Rev 7/2009

State

Registrar

20te

eeor

MAR 0 9 2011

31. Date filed (Month, Day, Year,

Baltimore, MD 21201

S. Greene St.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Medical 4a. Facility Name (if not in 208 t institution, give street and number)

8 Colgate Avenue Examiner 4c. County of Darthore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 3 M 2 X F Belgium 215-64-8815 (Month, Day, Year) 03/27/1950 60 **Director** Yrs Usual Residence of Decedent 28a-f shov 10a. State with the Maryland ms 23a or 28a-f sho must be notified at Director 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Dundalk 1X Yes 2 □ No 10g. Citizen of What Country?
Belgium 10e. Street and Numbe 10f. Zip Code Funeral 208 Colgate Avenue 21222 Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 XNever Married 2 Married 1 ☐ Yes 2 🛣 🛣 of If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Machine Operator Manufacture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid Marie Kuppi ၉ Stefan Mikolaenko 19a. Informant's Name/Relationship (Type, Print)

Julia Waters / Sister dess (Street and Number or Rural Route Number, City or Town, State Zip Cade) Parnell Ave., Baltimore, MD 21,222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) Final Journey Crem. 3/9/2011 Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshal Maryland Cremation Services PO Box 1413, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caust erval Between Immediate Cause (Final set and Death Ph_sician/ disease or condition resulting in death) 2 Medical Due to (or as a consequence of): Examiner Sequentially list conditions cause (Disease or linjury Due to (or as a done-quence of). Exami and I-transit the Hospital or Attending Physician; The law requires that the death certificate be executed thin 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Year signed by the a 1 Yes 2 L g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ certificate has been si rector, page 2 should b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tes မ neral Director: After this filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home Sesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 2 Accident
3 Suicide М 1 \square Yes 2 🔲 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

30. Namerand address of person who

ted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAR Physician/ Melvin F. Mislak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Atlantic General 8. Date of Birth (Month, Day, Yea Feb. 11 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🖳 M 2 🗆 F Hours 217-26-8318 Director 82 MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Berlin Worcester MD 1 Yes 2 v No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 14 Blue Heron Circle 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc Yes 2 No Yes, Give ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Brick Layer 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anastasia Nesobinska Benjamin Mislak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 Seneca Road Baltimore MD 21220 Michael Mislak /son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 3/5/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility 300 Connelly Funeral Ave Balto MD of Essex 21221 Mace Home 23a. Part 1. Enter the disease, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Jub dum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death been signed by the a should be detached to 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No) မှ Inpatient 2 🗆 ER/Outpatient 3 🗀 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and litle of certifie D56312 Healthway Drive, Berlin, MD 21811 death (Item 23a) (Type, Print) State Registrar

1	1-0	175	6	
P	an	lleh	McCall	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Randali McCali		· · · · · · · · · · · · · · · · · · ·	ificate of Death Reg. No.	07286
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last) Randall	McCall 2. Date of Death Month Day Year March 4, 2011	3. Time of Death 1630 hrs
		4a. Facility Name (if not institution, give street and number) 6231 Fairdel Avenue	4b. City, Town, or Location of Death Baltimore 4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 13-66-5144 1	Months Dave Hours Min	
nd show any sce.	7	Usual Residence of Decedent 10a. State MD 10b. County 10c. City, To	Raltimore	10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 6231 Fairdel Avenue	10f. Zip Code 10g. Citizen of What Count USA	ry?
er death wi	by Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? Army 1 Yes 2 No 3 Widowed 4 Divorced or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	
5-0036 led within 72 hours tygiene. other than "natur:	Completed	15. Decedent's Education (Specify only highest grade completed) 1 Elementary/Secondary (0-12) College (1-4 or 5+) 1 2	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer Construc	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than numatic event, the Medica	Be	17. Father's Name (First, Middle, Last) Frederick Wayne McCall	18.Mother's Name (First, Middle, Maiden Surname) Sharon Gatha Hamrick	
, MD 21 and 2 should ealth and Me tem 27 is ma traumatic ev	_	19a. Informant's Name/Relationship (Type, Print) Sharon McCall / Mother	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 1002 A. Markham Court, Bel Air, ace of Disposition (Name of cemetery. Date 20c. Location - City or T	MD 21014
Baltimore, MI permit. Pages 1 and 2 to Department of Health a Important: If item 27 injury or other traum		1 Burial 2 XCremation 3 Removal from State Fir	ematory or other place) nal Journey crem. 3/9/2011 Woodbine, M	D
	- 1	- JOHOLE M. WILLIAMS	22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD2 Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	1203 Approximate Interval
Physician Modical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Toxicity Complicating Atherosclerotic scular Disease	Between Onset and Death
	P P	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or):		
ted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
60, tte be executed hysician and e burial - transit	Medical	d. ☐ AMENDED 23a,pt.	II,27 per me g915 5-4-11 vt	
certifica	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant in the Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pregnancy Month Da	ay Year
P.O. E es that the d igned by the be detached		Part II. Other significant conditions contributing to death but not result through the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to death but not result to the conditions contributing to the conditions con	sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the sulting in the underlying cause given in Part I. 1 Yes 2 No 3 Proba	
on of Vital Records, P.O. Box anding Physician: The law requires that the death arth. After this certificate has been signed by the arte the funeral director, page 2 should be detached for u	Completed by			ppsy findings available impletion of cause of
ital Resident The sician: The sician: The irector, page	å	25. Was case referred to medical examiner? 1	26.Place of Death (Check only one) R/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 ✔ Other.	Scene
on of VI ending Physiath. or: After this	ition: To	27. Manner of Death X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 2	28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No	
Division of vospital or Attending Ph. Nours after death. Loureral Director: After turneral Director: After turneral Director.	Certification:	4 Homicide Could not be determined (Specify)	ne, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State)	al Route Number, City
2 - 2 >	Medical	one) 2 Medical Examiner: On the basis of examination and	e, death occurred at the time, date and place, and due to the cause(s) and manner as stated d/or investigation, in my opinion, death occurred at the time, date and place, and due to the	d. cause(s)
T Wis	We	and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Monto) O.C.M.E. March 5, 2011	th, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 2:	3a)	
Sta	ite		niner 900 W. Baltimore Street, Baltimore, MD 21223	
Registr	~	11 D 0 9 2011 Breed A. A.	PRIVATE AND	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2011 **Physician** February Constance Elaine Nicholas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** 135 N. Mechanic St; Apt 607 Cumberland Social Security Number 219-54-2028 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec 18, 1 7. Age (In yrs. last birthday) 6. Sex Funeral Months Days Hours Min. 1 □ M 2 🗓 F 1949 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Even inver roust be coulfied at MD Allegany Cumber land Director 10f. Zip Code 21502 10e. Street and Number 135 N. Mechanic St; Apt 607 Completed by Funeral 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2粒No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3₺ Widowed 4 Divorced r than "natural", the Medical Eve 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Audrey Jones William Kinsman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau once. 305 Pine Woods Apts; Ridgely, WV 26753 William H. Bradshaw Jr son 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4⊠ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Licensee Ronald S. Warde Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, others failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician pryscardent /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or eya consequence of) extersion burial-tra resulting in death) Last P.O. Box 68760, Physician/Medical the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 -No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 24a. Was an autopsy performed certificate 2 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 ₹No 1 Inpatient 2 ER/Outpatient 3 DOA မ within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification:

9. Birthplace (State or Foreign Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. white 16b. Kind of Business/Industry own home 20c. Location - City or Town, State Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

7:20

Ам

State Registrar 1 Anatural

2 Accident

3 ☐ Suicide

29a, Certifier

Medical

4 ☐ Homicide

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

J Ballino

MAR 0 9 2011

5 Pending investigation

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Nat'

and manner stated.

912

32! Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

10017565

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-01416 State of Maryland / Department of Health and Mental Hygiene Emmanuel Okutuga 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 19, 2011 1717 hrs Medical Examiner Emmanuel Okutuga 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Montgomery 4719 Colesville Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. December 3, 9 Birthclace (State or Spring 6. Sex **Funeral** Months Days Hours Director Country) Maryland 213-39-7643 1 X M 2 F 26 1989 1984 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show Maryland Montgomery "natural", or items 23a or 28a-f shov I Examiner must be notified at once. Silver Spring Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho
right? or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15121 Timberlake Drive 20905 United States Funeral 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married African-Yes 3 Widowed 4 Divorced Yes, Give Yeer 1 Yes 2 No specify: Specify: American ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bowie State Twelfth Three + Full Time Student University 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Godson Okutuga Olubunmi Comfort Oludipe 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olubunmi Comfort Oludipe/Mother 15121 Timberlake Drive, Silver Spring MD 20905 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State February crematory or other place 1 X Burial 2 Cremation 3 Removal from State Washington National 28,2011 Suitland Maryland Donation 5 Other Specify 22. Name and Address of Facility Robert G Mason Funeral Home Inc Donald R. 21. Signature of Funeral Service Licensee Gray 1661 Good Hope Rd SE, Washington DC 20020 Approximate Interval r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Nyltiple (2) Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit ician/Medical AMENDED #8perINF, G914, 4/28/2011, WS UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown į Unknown signed by the a Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 ✓ No 3 Probably 4 Unknown pleted ficate has been si, page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No this certificate 1 Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene 2 ER/Outpatient 3 1 Yes 2 No ٩ 28a. Date of Injury 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death 28c. Injury at Work? Feb 19, 2011 Shot by police 1 Natural 1700 hrs 1 Yes 2 No 5 Pending death. the 2 ___ Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 4719 Colesville Road, Silver Spring, MD Certi determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 20, 2011

hin 24 hours after death the Funeral Director:

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD 31. Date filed (Month, Day, Year) 32. Revisiter's Signature State Registrar ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ : 55 P. M Til ford Patterson March Medical Facility Name (if not institution, give street and number) Town, or Location of Death Examiner a mock Wn If Und If Under 24 Hrs 8. Date of Birth (Month, Day, Ye 9. Birthplace Country) State or Foreign **Funeral** 1 M 2 F Months lane Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Town or Location 10d. Inside City Limits 10b. County 10c. City, within 72 hours after death with the Maryland 10a. State Director 1 Yes 2 ☐ No more 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Completed 3 Widowed 4 Divorced lac Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' conday (0-12) College (1-4 or 5+) Sablea Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Las Sister) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name by 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State any injury or 4 Donation 5 Other (Specify) f Ineral Service Licensee 21. Signatur Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final preumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No signed by the a 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 🗹 No 1 Tyes been si should I Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed 1 🗌 Yes 2 🗎 No this certificate Yes 2 No 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) director, Be examiner? 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 2 🖳 No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident
Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MS Rajapanem. D DO057-465 3/9/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N ら Raypa KSE / M・D ・ Z835 Sm ITh A Y Baltimore, MD. 21209 5-203

DHMH 17 Rev 7/2009

State

Registrar

Year)

2011

31. Date filed (Month, Day,

. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a pt II 25 per me 9924 2-16-12 vt State of Maryland 1 Department of Health and Mental Hygiene) | | for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Marc 13:08 **Physician** /Medical 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number **Funeral** N.C **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 Yes 2 □ No Himore Director 10g. Citizen of What Country? 10e. Street and Numbe 3906 USA 21213 e19 Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specily: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specily only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Woman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ittle Tinnie ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3906 Chesterfield Pre Batto, MD 21213

Ice of Disposition (Name of Date 20c. Location - City or Town, State Hubano 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State sen Forest 3-11-2011 Owings Mills, MM
22. Name and Address of Facility March FH 1101 E. North A permit. Page Department o Important: If any injury or once. Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune Service Aicensee 1101 E. North Are, 21202 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertensive Heart Disease with Complications Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last IN APPROVED BYM Due to (or as a consequence of) CERTIFICATI Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specily) 2 No been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown Chronic Alcohol Abuse, Diabetes Mellitus, Sickle Cell 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Disease, Metformin Use autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check onl one 25. Was case referred to medical Be examiner? Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 5 ☐ Residence 6 ☐ Other (Specify) ၉ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral d 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation (Month, Day Injury 1 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specily) determined 4 Homicide 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of cortified 29c. License number RES - 000 March 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 KARTHIA SUR 31. Date filed (Morith, Day, Year) State MAR 0 9 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 Ypa eune KOC 215JPM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carroll 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MDountry) 1 🗆 M 2 🔀 F 214-16-8967 Months Days Hours Min 6-27 Day Year 0 Director 90 Usual Residence of Decedent · 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items be notified at injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City. Town or Location 10d, Inside City Limits Director MD Carroll Westminster 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3355 Sykesville Rd. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security 12 Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Urban A. Wright Mary Alwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie B. Bach-daughter 3355 Sykesville Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State South Carroll Crem 3-9-11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Winfield, MD 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lic 22. Name and Address of Facility Fletcher Funeral Home Thomas Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ ardi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attendion abusinan and the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 3 No Yes 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1 e and address of person who completed cause of death (Item 23a) (Type, Print) East Main Sheet Westminster MD 21157 32. Registrar's Si State Registrar

11-01549 Simon Rivers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

Simon Rivers Simo	y) Id. Inside City Limits Yes 2 No Polyonal Indian, Black, Astryunk Code) 23
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(Disease or injury that initiated events resulting in death) Last OPEN DED	
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99 Light Signature of the second seco	
past 12 months?	
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 22 Did tobaccourse contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobaccourse contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobaccourse contributing to death but not resulting in the underlying cause given in Part II. 23b. Did tobaccourse contributing to the cause given in Part II. 23b. Did tobaccourse contributing to the cause given in Part III. 23b. Did tobaccourse contributing to the cause given in Part III. 23b. Did tobaccourse contributing to the cause given in Part III. 23b. Did tobaccourse contributing to the cause given in Part III. 23b. Did tobaccourse contributing to the cause given in Part III. 23b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse given in Part III. 25b. Did tobaccourse contributing to the cause given in Part III. 25b. Did tobaccourse given	Year
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24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	sy findings available pletion of cause of
Position in the second of the	2 No
25. Was case referred to medical examiner? 1 Vexaminer?	
24a. Was an autopsy performed? The partial process of part of the process of part of partial process. The partial process of part of partial process. The partial process of part of partial process. The partial process of partial process of partial process. The partial process of partial process. The partial process of partial process. The partial process of partial process of partial process of partial process. The partial process of	
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of Control of Contro	use(s)
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Day, Year) Registrar NAR 0 9 2011 32. Registrar's Signature A gardel	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Pay 27,2011 4:40A.M Janet Ridge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore Stella Maris 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) England 8. Date of Birth **Funeral** (Month, Day, 1 🗆 M 2 🔽 F Months Days Director 212-48-4128 67 194 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2🔀 No <u>Maryland</u> Baltimore Halethorpe 10e. Street and Number 10g. Citizen of What Country? Funeral 4439 Scotia Road 21227 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Specify: 3 - Widowed - Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Marketing Sales 12 Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental I tem 27 is marked o permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Douglas Gilbert Beadle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah P. McIntyre 4439Scotia Road,Halethorpe,Maryland21227 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Ardent cremation 3-1-11 Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Prichael P. Marzulla- 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PANCREATIC CANCER disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas performed? Yes 2 X No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident М 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2011 28 30. Name and ardress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, -CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY G913 3/09/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wilhelm Physician/ Martin Schmidt March а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Helathcare Hyattsville Prince George Social Security Number 137-32-9712 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
02/02/1921 Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 90 Months Hours **Director** Romania Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director NJ Morris Kinnelon 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 07405 8 Dogwood Trail 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 White Hygiene. If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5 + Elementary/Seconday (0-12) Engineer Aerospace permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martin Schmidt Rosa Bedner ^{19a.} Informant's Name/Relationship (*Type, Print*) Rosemary Thorpe / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2621 Wynfield Road, West Friendship, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem! 3/9/2011 Woodbine, MD PO Box 1413, Baltimore, MD21203 Porgta Marshall 23a. Part 1. Enter the disease, or complications that caused I shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a gunsucumos of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) In the past 12 months?
1 ☐ Yes 2 ☐ No Day Year been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 2 AND 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy 1 Yes 2 No Yes 2 🕽 25. Was case referred to me Be 26. Place of Death (Check only one) examiner? 1 Yes 2 4 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of ath filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at : After 28d. Describe how injury occurred tural 5 Pending injury 1 ☐ Yes 2 ☐ No 4 hours after death uneral Director: / Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, 2014) License number d cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mr 4 М Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Baltimore Randallstown If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday, Social Security Number **Funeral** Date of Birth 9. Birthplace (State or Foreign 1 ☑ M 2 ☐ F Months Days Country) Virginia Yea[1928 Dec. 22 **Director** 230-26-0885 82 Usual Residence of Deceden 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No MD Baltimore Towson 10e. Street and Number ò ms 23a or must be n 10f. Zip Code 10g, Citizen of What Country? 305 E. Joppa Road Apt. 308 USA <u>21286</u> items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. the Medical Examiner Armed Forces? 14. Race - American Indian. Black, White, etc. ö þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗹 No "natural", Specify Completed 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the ME Elementary/Seconday (0-12) 6th Grade College (1-4 or 5+) Construction Worker Harry T. Campbell Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Thomas Henry Scott Emma Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odessa Scott - Ex-Wife 20 Windy Falls Way Cockeysville, Maryland 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 3/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Man. Car. Timonium, Maryland Signature of Funeral Source Lineary e 22. Name and Address of Facility Chatman Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 499 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Live Birth 2 ____ retail ____
Pregnant at time of death
Unknown Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t director, page 2 s autopsy 1 Yes 2 No Yes : After this certifica e funeral director, p Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? hos 1 🗌 Yes 2 X No Other: မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗀 4 Nursing Home 5 Residence 27. Manner of Death Certificate: Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No Accident within 24 hours after death To the Funeral Director: / completed filled in by the f Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Physician/ 338pm DYDE ELMER SHORE 2011 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) MD **Funeral** Days Months Hours Min. (Month Day, Year) 59 Director 220-68-1022 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State Completed by Funeral Director 1 🛚 Yes 2 🗆 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21223 1917 Wilkens Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 K No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Salvage Owner; Operator 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cloyde Elmer Shore Sharen Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Lucabaugh Mill Rd., Westminster, MD 21157 James H. Shore - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 03-07-11 Marriottsville, MD Crestlawn Mem Gdns. : 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Funeral Service Licensee MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ andida Gabrata Medical resulting in death) Examiner Nonalcoholic supertially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hepatitis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No မ 1 XInpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 24353 MARCH OR 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JASON A. INCORVATI BALTIMORE MD 2 SOUTH GREENE ST.

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 17,18 per fh g913 3-9-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 7 2011 Bernard Joseph Setlak 12:30pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 3608 E Northern Pkw. Baltimore City Baltimore City If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 214 03 3750 1 🖳 M 2 🗆 F 96 Months Days Hours October 7º 1914 Bartimore Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore City Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? with t Funeral items 23a 3608 E Northern Pkwy. 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black White etc. 1 Never Married 2 Married "natural", or ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 is mand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Bethlehem Steel (Kev Hwv) Welder other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ - Hakaawa Eva Klejnowska John Setlak pernit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine F. Baliko 7706 Wilson Avenue Baltimore, Maryland 21234-6906 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Cem. March 11 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Sign Jure of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 20ther 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final arterioselentic Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence or): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 4 No 1 Yes 10 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 121022 Maran 3-8-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OCAIR rd. BATU.MD21236 Kay C ALOWSKI 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Viola Wanda Setlak March 7 2011 11:57р м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Gilchrist Hospice Center Towson 5. Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 DF Days Hours Min. JUIV 24 1914 Balttimbre, Maryland 96 Director 214 03 3751 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral LISA 21206 3608 E. Northern Pkw. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sophia Unknown John Wisniewski 19a. Informant's Name/Relationship (Type, Print)
Geraldine F. Baliko (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7706 Wilson Avenue Baltimore, Maryland 21234-6906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XX Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. March 11 2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee ²³ Name and Arthrese of Figure 1 inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence or, physician and the burial-trans Due to (or as a consequence of): Physician/Medical that the death certificate be use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ned by the atter edetached for u in the past 12 months? Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv certificate ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: i within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 0 N

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month_Day Year)

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 74111 Physician/ Snyder Eli Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Glen Burnie Baltimore-Washington Medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Sex 1 X M 2 □ F April 16,1922 Washington D.C Months **Funeral** 88 145-12-0088 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot amjoritant: If item 27 is marked other than "natural", or items 23a or 28a-f shot amjory or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 Yes 2 No Director Pasadena Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 Funeral 683 DuVall Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?
1 ★ Yes 2 No
If Yes, Give 1 Never Married 2 Married ģ 1 Yes 2 XNo Specify: White Baltimore, Maryland 21215-0036 3 Divorced Year or Dates Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) N /A Elementary/Seconday (0-12) U.S. Army Soldier 5 4 1 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Unknown ည Unknown Snyder Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Maryland 21122 683 DuVall Highway Pasadena, <u>Marianne G. Snyder (Wife)</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge Maryland 03/10/2011 Pk. Meadowridge Mem. 4 Donation 5 Other (Specify) McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and s the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ttending physician for use as the burlan Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month Day in the past 12 months? Box Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown ate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 3 Probably 4 Unknown Completed by 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be **Division of Vital** Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? 1 npatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 2 No ၉ After this c 28d. Describe how injury occurred 28c. Injury at 28b. Time of 28a. Date of injury 27. Manger of Death Certificate: (Month, Day, Year) injury 1 Alatural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation To the Hospital or Attendil within 24 hours after death. To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be City or Town, State) determined completed filled in by Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d Date sig and title of c rtifie 29b. Signature

State

Registrar

ack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WU

31. Date filed (Month, Day, Year)

MAR 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marchi 8, 2011 Rose A. Smith 7:15 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Genesis Health Care Severna Park Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, 1 🗆 M 2 🖫 F Months Days Hours 213-20-6315 **Director** Sept Maryland Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MDBaltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 324 Orchard Avenue 21225 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Hame Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Max M. Addis Sarah Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome Alfinito 324 Orchard Avenue Baltimore, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 K Burial 2 Cremation 3 Removal from State any injury or Glen Haven Memorial Park March 11, 2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Unense 22. Name and Address of Facilit McCully Polyniak Funeral Home P.A. 237 Fast Patapsco Avenue Baltimore, MD 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Congestive Herent Fri I eve disease or condition resulting in death) deen Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as the yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Tes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Box 68760 P.O. Records, Division of Vital within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral To the Hospital within 24 hours a To the Funeral C

Baltimore,

State Registrar

Medical

29a. Certifier (Check

29b. Signature and title of certifier

Michaelt Dout

31. Date filed (Month, Day, Year)

MAR 0 9 2011

Keny Dent

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

march 8, 2011

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Stewart 5:45 M 201 Medical 4a. Facility Name (if not institution, give street and number)
Joseph Richey Hospice
838 N. Eutaw St 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 X F Months Hours (Month, Day, Year, **Director** 213-62-4779 14-1937 Portemouth VA Usual Residence of Decedent or 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5316 Wesley Avenue 21207 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural", Specify: Completed 3 Divorced 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pactory Line Worker 12th grade Cosmetics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည permit. Page 1 and 2 should be I Department of Health and Menta Important: If item 27 is marked Wyatts illie illian 19a. Informant's Name/R-lationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doreathin Blick Baltimore 5316 Wesley Avenue mo other 20c. Location - City or Town, State 3400 Hellins Ferry Rd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Mt Cem: 3-11-2011 Baltimore, MD 21227 4 ☐ Donation 5 ☐ Other (Specify) TRI- State Funeral Services 21. Signat f Funeral Service Licensee 22. Name and Address of Facility 814 upshur St N.W. Washington DC 20011 w. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ a Non-small cel disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 2 months Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 4 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of The law has autopsy performed? Yes 2 X No death? certificate 1 Yes To the Hospital or Attending Physician: Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 4 Nursing Home 5 Residence 6 Nother Specify Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural iniury 5 Pending within 24 hours a er deau.

To the Funeral Director: Af 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier R107936

State Registrar 828 N. Eutaw St. Baltimore MD 21201

VP Joseph Richey House, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Menino

31. Date filed (Month, Day, Year,

MAR 0 9 2011

CRNP

11-01828	
Charles Wilbur Saylor, Jr.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Zilaries Wilbur S		1- For State Registrar	te of Maryland /		ment of Healicate of Deale			201	07304
Physicia Medical Exami		Oecedent's Name (First, Middle, I Charles	-ast) Wilbur	Sayl	or, Jr.		2. Oate of Oea Month March 7,	Day Year	3. Time of Death 1026 hrs
2		4a. Facility Name (if not institution, 205 East Joppa Road #	give street and number)		4b. City	y, Town, or Location		4c. County of Deat	
Funeral		Social Security Number 6		(In yrs. last	birthday) If U	nder 1 Year If Und		irth (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		218-28-4236 Usual Residence of Decedent	X M 2 F	7	9 Yrs. Moi	nths Days Hou	rs Min. 09/0	6/1931 Forei	ountry) MD
w any	Ì	10a. State 10b. County		•	wn or Location	<u></u>			10d. Inside City Limits
uyland la-f show	Director	MD Ba	ltimore		owson 10f.	Zip Code		10g. Citizen of What Cou	1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Dire	205 East Joppa	Road #1509			21286		U.S.A.	,
11. Marital Status 12. Was Oecedent Ever in U.S. 13. Was Oecedent of Hispanic Origin? (Specify Yes Period 1) Never Married 2 Married 2 Married 1. Was Oecedent Ever in U.S. 14. Was Oecedent of Hispanic Origin? (Specify Yes								o- 14. Race - Ame White, etc.	rican Indian, Black,
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d within ygiene.	E	17. Father's Name (First, Middle, La	ast)		PUSTIIIdS		er's Name (First, Middle,		tal Service
21215-0036 wild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	æ	Charles Will 19a. Informant's Name/Relationship	,	or, Sr		S	usan	Cunnin	•
	٩	Susan Grace Cari		er			Upperco, MD	mber, City or Town, State 21155	e, Zip Code)
Baltimore, N permit. Pages I and Department of Healt Important: If item injury or other trau		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Stat	20b. Plac	ce of Disposition (N matory or other place KWOOD Cer	lame of cemetery, ce)	Date 03/12/11	20c. Location - City o	·
altim mit. Pa partmen portant ury or o	ŀ	4 Donation 5 Other Social 21. Signature of Funeral School Ce Lice	my: censee William					on Funeral	
m 원리트로 Physician	-	23a. Part I. Enter the disease, or co	mplications that caused the	he death. Od			., Towson,		Approximate Interval
/M idal xaminer		failure. List only one ceuse on Immediate Cause (Finel disease	each line. a. Intra-Oral Gunsh						Between Onset and Death
		or condition resulting in death) Sequentially list conditions,	Due to (or as a consect b.	quence of):					
a ^{ger}	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec	quence of):					
executed in and il - transit	Exai	events resulting in death) Last	Due to (or as a consect	quence of):					
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Ox 6876 eath certificate attending phy for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome		2 Fetal dea	th 3 Ectop	oic pregnancy	23d. Date of deliver Month	y Day Year
Box e death c the atten	Physician/	1 Yes 2 No 9 Unkno	9 Unknown		o ∐ Other (o)			1	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	2	Part II. Other significant condition Lung Cance		but not resu	iting in the underlyi	ing cause given in P		obacco use contribute to es 2 ✓ No 3 Pro	
cords, law require has been si 2 should b	Completed		-		-		24a. Was	an 24b. Were a	utopsy findings available completion of cause of
	E S			-			perfo	ormed? death? 2 No 1 Y	•
Vital F ysician: 'ysician: director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatien	t 2 ER	N/Outpatient 3	. IOther	Nursing Home 5	Residence 6 🗸 Othe	r: Scene
	Di:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury FOUND: Day, Yea	/ 28 ar) F	b. Time of Injury	28c. Injury at Wor	Subject che	how injury occurred ot self	
Division pital or Attendi ours after death. ceral Director: /	Certification:	2 Accident Investig 3 Suicide 6 Could n	ation Mar 7, 2011		020 hrs e, farm, street, facto	ory, office building, e	etc. 28f. Location (Street and Number or R	ural Route Number, City
Di Tospital 4 hours a "uneral"		4 Homicide determi	(Specify) Mult		·	the time data and a	·	pa Road # 1509, Tov	
Divisi To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	one) 2 Medical Examin	ner:On the basis of exam and manner stated.	ination and/o	or investigation, in	my opinion, death o	occurred at the time, date	and place, and due to the	ne cause(s)
*	≥	29b. Signature and title of certifier	9/0/1	MO	2	O.C.M.E.	r	29d. Oate signed (Mo March 8, 2011	nth, Day, Year)
) I		30. Name and address of person wh						1	
Sta	ate	Victor Weedn MD JD 31. Date filed (Month, Day Yeer) MAR 0 9 2011	Assistant Medical I	Signature		timore Street, E	Baltimore, MD 212	23	
Regist	rar	MAKU 9 ZOTT	knewa B.	bar	الما				

State Registrar

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

DHMH 17 Rev 1/2001

7758 Wisconsin Ave., Suite 211, Bethesda, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Roy Fried, M.D.,

31. Date filed (Month, Day, Ye NAR 0 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 24a per doc g913 3-9-11 vt
State of Maryland / Department of Health and Mental Hygiene amend #5 Per FH G913/28/2011 att 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year 804a.M February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 6. Sex 1 🖾 M 2 🗆 F If Under 1 Year If Under 24 Hrs. Security Number **-28-2668** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, 0.7 77 **Director** PA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or orher traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 427 Wingate Road 21210 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ð 1 ☐ Never Married 2 ☑ Married 1 X Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Professor of Physics CCBC Catonsville Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Sawyer Laura Prouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 Wingate Rd. Baltimore, MD 21210 Janet Walsek/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 3-3-2011 Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crem. any in 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Athleroscheronic DISCUSE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner ude to (or as a consequence of) the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Autonomic Dyskunition 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsv prior to completion of cause of death2 1 Yes 2 □ No performe 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 은 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 1, 2011 B19916795 mD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Buthmore maryland 21218 201 Parkway Meghan East University 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Michael F. Susa 7:20A.M March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Home Middle Baltimore River 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F **Funeral** Feb. 5 Hours Min. Pennsylvania 86 **Director** 189-14-5795 Usual Residence of Decedent 28a-f shov 10a. State 10b, County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3611 Red Rose Farm Road 21220 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married Married 1 ☐ Yes 2X No Specify. White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Manufacturing æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Susa Agnes Sestock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Susa/ Wife 3611Red Rose Farm Road,Middle River,Maryland Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition

1 Description

1 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State St.VincentCemetery 3-7-11 4 ☐ Donation 5 ☐ Other (Specify) Latrobe, Pennsylvania 22. Name and Address of Facility Marzullo Funeral Chapel, P.A 21. Signature of Funeral Service Licensee 6009Harford Road,Baltimore,Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due t the attending physician and shed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Ď icate has been signe r, page 2 should be c 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? ☐ Yes 2 X No 1 🔲 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 힏 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, SICIAN IND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ERMAINE 30.DD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SILVER SPRING ONTGOMER Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 D F **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ANDOVER 10e. Street and Number 10g. Citizen of What Country? Funeral 20785 SVA 650 FOREST 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 - Widowed 4 - Divorced Specify: BLACK Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry th and Mental Hygiene.
It is marked other than "r traumatic event, the Med (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFIBNI 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname, ERMAINE RIDIEU NICOLE MICHELLE ANDREA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOSPUTA 20919 CROSS FORE BN NO 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🛱 Other (Specify) In State cemetery, crematory or other place) Signature of maral Service License Nonal 22. Name and Address of Facility State Anatomy Board Mrector 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ BXLBEWE REMATURIT disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PREMATURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conyibute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Q the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge deeth 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 33064 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY NICK 201 N. FREDERICK ALIB CAITHERBURG MD 208TT

State Registrar mature market

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ VASBINDER Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Season's Hospice Baltimore Randallstown 8. Date of Birth (Month, Day, Year) 01/17/1948 Birthplace (State or Foreign Country) Social Security Number 165-40-6787 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 🗆 M 2 🛣 Months Hours 63 Yrs. Director Usual Residence of Decedent fshow ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Xes 2 No 10f. Zip Code 21093 10e. Street and Numbe 10g. Citizen of What Country? USA Funeral 2 Cormer Court, Apt. 102 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examina once. ğ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Services 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Moyer Bicker ည Louis 19a. Informant's Name/Relationship (Type, Print)
Clarence C. Geibel / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code
2 Cormer Ct. Apt. 102, Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 \square Burial 2 X Cremation 3 \square Removal from State cemetery, crematory or other place) Final Journey Crem. 3/7/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland
PO Box 1 Signature of Funeral Service Licensee Dorota Marshall d Cremation Services 1413, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ einco disease or condition resulting in death) amo Medical to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) l by the attending physician and stached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? performe Yes 2 No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Special Special Sp hours after death, ineral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title MO and address of person who completed cause of death (Item 23a)

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32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day MG **Physician** 04 2011 10 2000UC /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth
(Month, Day, Year)
June 21,1943 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 5. Social Security Number **Funeral** Months Days Hours Min 1 🗆 M 2 🕱 F Georgia 175-34-7672 67 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 🙀 No ed other than "natural", or items 23a or 28a-f s event, the Medical Examiner must be notified Director PA Allegheny Pittsburgh 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 134 East Bruceton Road 15236 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status 1 ☐ Never Married 2 🕱 Married Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Specify: 2 White 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Environmental Elementary/Secondary (0-12) Special Projects Equipment 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Kish George A. Dragan ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 134 East Bruceton Road Pittsburgh, PA 15236 John Mark Place (Husband) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Allegheny crematory mather place 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-8-2011 Pittsburgh, PA Crematory 22. Name and Address of Facility Witzke Funeral Homes, Inc. Columbia, MD 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only of cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METAS TATI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): -transit The law requires that the death certificate be executed and Due to (or as a consequence of) burial Division of Vital Records, P.O. Box 68760, attending physiciar Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 2 🗶 No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 2 X No 1 Tes completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence Hospital: 2 X No 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 X Inpatient ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: or Attending 5 Pending investigation 1 X Natural 1 🗌 Yes 2 □ No death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier S ES-000 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

ORIGINAL

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 2913 3-9-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Pauline Gertrude Wagner Physician/ 2011 6:00A M March 3 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sabillasville 17010 Sabillasville Rd. Frederick 8. Date of Birth (Month, Day, Year) 2 – 7 – 1917 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Min. 1 □ M 2 🏻 F Months Days Hours 94 MD Director 213-05-7473 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director PA Adams 1 Yes 2X No Littlestown 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 346 Lafavette Dr. 17340 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatin. Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Worker Shoe Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William G. Stonesifer Ida Stonesifer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy McKinney-daughter 1687 Exeter Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3 - 7 - 11Westminster Cem Westminster Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Juneral Service Licensee Melun 254 E. Main St., Westminster, MD 21157 formas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ PULMONARY EMBOLISM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner THEOMBOSIS YENOUS Sequentially list conditions, Examiner in any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of: use as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTONSIVE CORONARY MISCULAR DISTORSE/ATRIAL 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed FIBRILLAR 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PULMONIARY DISBASE CHEONIC autopsy performed? Diverticulosis 1 ☐ Yes 2 ☐ No Calfick Colitis certificate 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be daughter's examiner? Hospital: Other: 4 Nursing Home 3 Thesidence 6 X Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 IDOA မ within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No 1 Natural 5 🗀 Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN 2115 MARCH 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pook Read WESTMUSTER Denner 700-B 31. Date filed (Month, Day, Year) MAR 0 9 State Registrar

Certificate of Death ADecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** IVer If Under If Under 24 Hrs. Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Social Security Number 278-28-4794 Funeral Months Days 1 □ M 2 🖾 F Hours Ohio Director Aug 12, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ire. Menter Exercites must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Funeral Director Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 9609 Norfolk Ave. 10f. Zip Code 20723 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Be Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Ethel Simkins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clark White - son 9609 Norfolk Ave; Laurel, Maryland 20723 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) In state 21. Signature of Funeral Service Ronald 22. Name and Address of Facility State Anatomy Board Director 3a. Part1 Enter the discusse, in complications that caused the shock, in heart failure. List only one cause on each line. Immediate Cashe (Final disease or condition resulting in death) 655 W. Baltimore St; Baltimore, MD 21201 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** over /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 14No 1 □Yes 1 ∐Yes 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Shursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 🖼 Þlo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Aatural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10estatePerMANA and / Gebart 128/2014 alt Hand Mental Hygiene

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

4333

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 2 0 1 1 Vandalear Venita Walker 5:25p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien nursing home Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days Hours Min 1 0 7 2 9 7 Maryland 215-54-1060 1949 61 Yrs Director Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 XYes 2 No MD N/A Baltimore 10e. Street and Numbe 10g. Citizen of What Country? must 2645 N. Calvert St. 21218 S.A be filed within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black Completed | 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. years office Manager N/A ith and Mental Hygiel 27 is marked other traumatic event, the other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Oliver R. Walker Ethel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Tyra Walker(sister) 8813 Flagstone Dr., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial 2 XCremation 3 ☐ Removal from State on-site Cremation 53/04/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Josephdd H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD2 21. Signature of Funeral Service Licenses MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Mehr-Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Por Day Pregnant at time of death 5 Other (specify) been signed by the s Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 1 ☐ Yes 2 ☐ No certificate Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c Injury at 28d. Describe how injury occurred after death. Director: After iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 1 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070076 m. D. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp-2/234 wood Re (U

DHMH 17 Rev 7/2009

ORIGINAL

32.

31. Date filed (Month, Day, Year)

State Registrar PATIENT KNOWN AS ROLAND, YOUNG

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carroll Allen, Jr. Feb 2011 16, 4:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number Age (In yrs. last birthday) 6. Sex 1 M 2 □ F **Funeral** Min. March 31 Months Days Hours 1944 Loudoun Co., VA 66 224-52-2380 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10c. City, Town or Location 10a, State Director 1 XYes 2 No MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 719 Richie Ave. USA 20910 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
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To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Other (specify) Pregnant at time of death 1 Yes 2 g 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Certificate: To 2 X No 1 Tes 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 2 Accident 5 Pending Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number

State Registrar e and address of person who/completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Ye ar 201 **Physician** 19, Evelyn Anna Ashby February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Co., Memorial Hosp. Oakland Garrett If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🙀 F 89 **Director** 216-22-6492 20,1921 WEst Virginia June Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Exaction man be notified at Director 1 ☐ Yes 2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 362 Ashby Cemetery Rd. 21550 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after deay Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify white þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Homer Koontz Rosa Severe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Young/daughter 93 Ashby Cemetery Rd., Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oakland Cemetery Feb 23,2011 Oakland, MD 22. Name and Address of Facility Newman Funeral Homes, P.A 21. Signature of Funeral Service Licensee 203 S. 2nd St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LEum /Medical Due to (or a a consequence of): Examiner WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) -transit law requires that the death certificate be executed and physician a s the burial-t Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 C Ectopic pregnancy Month 5 Other (specify) 2 INO as been signed by the 2 should be detached 1 TYes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy The performed2 1 ☐Yes 2 ☐No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🖪 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Year) 32. Regis

Kenneth Buczynski,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 311 N. 4th St., Oakland, MD 21550

32 Registrar's Signature

A. Sawl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12, **Physician** 2011 0740 Joe Louis Ancrum, Sr. FEB. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dorchester Cambridge Mallard Bay Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 XM 2 ☐ F South Carolina 218-48-6281 64 Dec. 12, 1946 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a, State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examination profilied at Cambridge 1X Yes 2 □ No Dorchester Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 72 hours after death with 21613 520 Glenburn Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. ò 3 Widowed 4 N Divorced Completed 16b, Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 73 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Poultry Chicken Processor 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) Be Verdell Ancrum Jacob Green, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110 Gardens Court, Federalsburg, MD 21632 Tonya Ancrum/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cambridge, 02/14/11 Mid-Shore Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, PA 21. Signature of Funeral Service Licensed

Multiple 7. 4 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Deset and Death Immediate Cause (Final physema 4 CONS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter the caus Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical death certificate the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day ģ in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 ☐ No 2 No.No 1 Yes Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director; After this certifice 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca (Check only one) Medi and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State Registrar

DHMH 17 Rev 1/2001

181

on who completed cause of death (Item 23a) (Type, Print)

ON SON 100 Bramble

ar) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 3:32 A M **Physician** Feb. 2011 Ruby Pauline Agnew /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Garrett 0akland Garrett Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Days Hours Min. 1 □ M 2X F 65 Yrs Maryland April 9,1945 Director 236**-**68-2559 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinating the multifled at 1 ☐ Yes 2X No Director Mount Storm WV Grant 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 26739 HC 76, Box 637 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 K No Specify: No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora Virginia Grabil Oscar Lee Day 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WV 26739 <u> Charles T. Agnew / Husband</u> 76, Box 637, Mount Storm, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Locust Grove Cemetery 03/02/2011 Mount Storm, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Schaeffer Funeral Home, 11 N. Main Street etersburg, WV 26847
per the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause op each line. Do not e Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequ Examine Hospital or Attending Physlcian: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.Of Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Year Month 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 3 Probably 4 ☐ Unknown 2 7 No. 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 10 13 08 2 No 1 ☐ Yes 1 🗆 Yes this certific al director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 1 ☐ Yes Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending investigation Injury 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

(Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

signed b d be deta the

Be Completed by page 2 director 2 After th funeral Certification: 4 hours after dea. within 24 hours af To the Funerel D Medical

Physician

/Medical

Examiner

Funeral

Director

ral', or Items 23a or 28e-f show Execution must be notified at

"natural',

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic events.

Physician

burial-transit

the use as

physician and

Examiner

Physician/Medical

Is marked

Director

Funeral

þ

Completed

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

ould be i

State Registrar 29b. Signature and title of certifier maryllera

E. Craig

31. Date filed (Month, Day, Year,

MAR 0 8 2011

29c. License number D0054573 29d. Date signed (Month, Day, Year)

30. Name and address of person who ampleted cause of death (Item 23a) (Type, Print)

Jarretsville, MD 21084

3718c Norrisville Rd 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 02/11/2011 Physician/ 8:59P M Spencer Marion Bracey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Min 1 🕅 M 2 🗆 F (Month, Day, Year) 01/04/1927 South Director Carolina 247 32 6734 Usual Residence of Decedent Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Chevy Chase 1X Yes 2 No MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20815 United States Funeral 4701 Willard Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 1949-Black, White, etc. 1 Never Married 2 Married 5 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** Specify: 1976 Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Armed Forces US Army Colonel Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Rachel Boykin Edward Whitaker Bracey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4701 Willard Ave., #1734 Chevy Chase, MD Mattie Riley Bracey/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 06/10/2011 Arlington, VA 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Washington, 20016 5130 Wisconsin Ave., NW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death collowouler a Immediate Cause (Final terosclesofic Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Due to for as a consequence of Examin Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 20:5 yes, outcome of pregnancy 23d. Date of delivery 23b, Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Other (specify) Pregnant at time of death signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Bracky, Spencer has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 5 Yevelny Ginchesman 201, Behesda, MB 208/4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Secree Four 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 9:51p M Alfred Laurence Beer 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 09 9. Birthplace (State or Foreign Country) Texas 7. Age (In yrs. last birthday) If Under Min. 1 🛛 M 2 🗆 F Months Hours 63 459-76-8190 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Bethesda 1 - Yes 2 1 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20814 5412 Burling Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) U.S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Energy Legislative Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Muriel Danzer Arnold Robert Beer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

Judean Memorial Grdns 02/18/2011

5412 Burling Road, Bethesda, Maryland 20814

22. Name and Address of Facility Hines-Rinaldi Funeral Home,

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

February 16, 2011

Olney, Maryland

28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

For State Registrar

10a. State

Director

Funeral

by

Completed

Be

2

20a. Method of Disposition

Sandra M. 31. Date filed (Month, Day, Year)

7

Linda Rochelle Beer - Spouse

1 X Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

21. Signature of Funeral Service Licensee

Physician/

Medical

Examiner

Funeral

Director

Physician/ Medical Examiner

Examine ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funetal Director. After this certificate has been signed by the attending physician and bompleted filled in by the Innerial director, page 2 should be detached for use as the burial-fraget. Be Completed by Physician/Medical ျှ Certificate:

Division of Vital Records, P.O. Box 68760

	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of):								
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. The Indicate cause (Disease or iinjury that initiated events resulting in death) Last Bacteremia Due to (or as a consequence of): Gastrointestunal Bleeding Due to (or as a consequence of): Respiratory Failure d. Respiratory Failure								
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	olivery Day Year							
ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia 23e. Did tobacco use contribute to t								
Complet	Multiorgan Failure End Stage Renal Disease 24a. Was an autopsy performed? death? 1 \(\text{Yes} \) 2 \(\text{N} \) No 1 \(\text{Yes} \)								
Be (25. Was case referred to medical examiner?			26. Place of Death (Che	ck only one)				
일	1 ☐ Yes 2 🔀 No	Hospital: 1 🗶 Inpatient 2	BR/Outpatient 3 □ [Other: 4 Nursing I	Home 5 Residence	6 Other (Spec	cify)		
Certificate: 1	27. Manner of Death 1 🔀 Natural 5 🗌 Pending 2 🗒 Accident Investigation								
Certif	3 Suicide 6 Could not b 4 Homicide determined	1 28e. Place of Injury - At h	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Inc.) City or Town, State)						
Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examinations se Practioner: To the best of m	on and/or investigation, in	n my opinion, death occurred	at the time, date and pla	ice, and due to the	cause(s) and manner stated		

D59980

8600 Old Georgetown Road, Bethesda, Maryland 20814

20b. Place of Disposition (Name of cemetery, crematory or other place

DHMH 17 Rev 7/2009

State

Registrar

ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 19, 2011 9:18A George Amory Burroughs February 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Charles Charles County Nursing Rehab Center La Plata Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)

oruary 26,1928 If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number Months Days 212-34-4656 February Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No St. Mary's Charlotte Hall 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20622 38000 Mt. Wolf Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2X No Specify: White Specify: 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Farming Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Rudolph Burroughs Mary Maude Ryce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9895 Marshall Corner Rd. White Plains, MD Garner Burroughs/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Christ Church Cemetery 2/24/2011 Wayside, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M 1458 21. Signature of Funeral Service Li AREHART-ECHOLS FUNERAL HOME, P.A. 20646 211 St. Mary's Ave. La Plata MD Approximate Interval Between Onset and Death Part 1. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of Due to (or as a consequence of

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

ð

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 7 to Mutcal Econning must be confined as

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

and

as the burial-trans eral Director: After th filled in by the funeral

Be

Certification: To

Medical

certificate

24 hours after death e Funeral Director:

within 2 To the

Hospital or Attending Physician;

Division of Vital Records, P.O. Box 68760

Ical Evalilli	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Completed by Filysicial/Medical Evaluit	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
u by ri	Part II. Other significant condition
analdii	
5	25. Was case referred to medical

FEMALE: ib. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown
rt II. Other significant condition	s contributing to death but not resulting in t

								_
ile	De	ementio	7					
:								
3 Ectop 5 Other		nancy fy)			23	3d. Date of deli Month	very Day	Year
he underlyir	ng caus	e given in Part I.		23e. Did tobacc		e contribute to		
				24a. Was an autopsy performed? 1 □Yes 2 XI		24b. Were au prior to death? 1 □ Yes	completion	on of cause of
		26. Place of Dea	ath (Check only one)				
atient 3	DOA	Other: 4X Nursing H	lome	5 ☐ Residence	6	☐Other (Spec	cify)	
me of ury M	28c.	Injury at Work? 1 □ Yes 2 □ No	d. Describe how in					
n, street, factory, office			28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
death again	unad at	the time data and plac	0 20	d due to the cause	0/e\	and manner as	stated	

	examiner? 1 ☐ Yes 2 🛣No	Hospi	ital: 1 Inpatient 2 I	ER/Outpatient	3 🗆 D0	OA Other: 4	X Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)
		ending ivestigation	8a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M 2	28c. Injury at Work? 1 ∐Yes	2	28d. Describe how injury occurred
l		ould not be etermined 2	8e. Place of Injury - At he building, etc. (Specif	ome, farm, street (y)	t, factor	y, office		28f. Location (Street and Number or Rural Route Number City or Town, State)
	29a. Certifier 1 Cer	rtifying Physicia	an: To the best of my kno	owledge, death o	ccurrec	at the time, d	ate and place	e, and due to the cause(s) and manner as stated. Urred at the time, date and place, and due to the cause(s)

29b. Signatu	ire and title	e oprogentin
	Min	Xe,
,	10 100	-

D0057999

29c. License number

29d. Date signed (Month, Day, Year) February 21, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrace Drive Stelo3, waldorf. Janiwale, MD 11637 anisha

2034 State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month 4:00 20 Norma Jean BENNER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown 15909 Broadfording Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Days Min Months Hours Maryland 1942 68 Yrs Director Aug. 212-38-9804 Usual Residence of Decedent shov 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland Director must be notified 1 ☐ Yes 2X No 28a-f Hagerstown Washington Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Funeral "natural", or items 23a USA 21740 15909 Broadfording Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 X No Specify: Specify White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Restaurant Services 10 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emmie Fayebelle Hines Norman W. Gerberich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5909 Broadfording Road, Hagerstown, Md. 21740 <u> John Benner - Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 2/25/2011 Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature eral Service Licenses 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician Coronary disease or condition Medical resulting in death) Due to (or as a consequency of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death n signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1

Yes 2 □ No 3 □ Probably 4 □ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 \(\subseteq\) Nursing Home 5 \(\vec{\subseteq}\) Residence 6 \(\subseteq\) Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ျ funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After injury Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director: A Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Hospital Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certif 29d. Date signed (Month, Day, Year, D0026579 MD 20/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, Medical Campus

27H-10 State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day,

Registrar's Signatur

le

Ą 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ , 2011 8:10 pM Donald Frederick BECKER ebruary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death . County of Death Baltimore **Examiner** Freater Baltimore Medical Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days 1 X M 2 - F Months Hours (Month Day Year) 3/26/1930 Pennsylvania 80 Director 200-24-3685 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number should be filed within 72 hours after death with the and Mental Hygiene.

is marked other than "natural", or items 23a is marked other than "natural", or items 25a is marked other than "natural", or it Funeral 21740 USA 17917 Sand Wedge Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married ξ Baltimore, Maryland 21215-0036 ☐ Yes 2 🗓 No Specify White Korean 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Mfg. Machinist/Supervisor 12 Be any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Marie Helsel Frederick Conrad Becker 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 17917 Sand Wedge Drive, Hagerstown, Maryland 21740 Barbara L. Becker - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State Hagerstown Crematory 2/23/2011 Hagerstown, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ noxR a disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed certificate l 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending 1 Natural work 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of confi 29c. License number 29d. Date signed (Month, Day, Year) 004 who completed cause of death (Item 23a) (Type, Print) SH-3+1 HOPKINS LANE 28 OWINGS 31. Date filed (Month, Day, Year) egistrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Leary Bryant, Jr. 02 8 2011 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Thomas More Nursing & Rehab Cntr. Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**x** M 2 □ F Months Days Hours Min. Director 244-68-6231 01/11/1945 North Carolina Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director tXXYes 2 □ No DC None Washington 10e, Street and Number apt#110E 10f. Zip Code 10g. Citizen of What Country? 9 must be 23a Funeral 3400 Commodore Joshua Barney Dr. USA items ; 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian ed other than "natural", or ite event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married Ş Yes 2x No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th <u>Self-Employed</u> <u>Service Repairman</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 20 þe Leary Bryant, Sr. Hannah Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20018 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3400 C.J. Barney Dr., NE apt.#301 Washington, DC LaVita Lawson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 03/02/2011 | Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cirrhosis of Liver Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Alcohol Abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Congestive Heart Failure To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month 4 Pregnant Pregnant at time of death 1 ☐ Yes ∠ L g ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? certificate 1 ☐ Yes 2 🙀 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ 4 🔀 Nursing Home 5 🗌 Residence 6 🗋 Other (Specify) this s after death.

I Director: After this of in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 hours aft

To the Funeral Di

completed filled in

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tanyech P. Walford 8200 Good Luck Road Road Lanham, MD 20706

1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year,

02/23/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Berry February 0600 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 DC Funeral Months Days Hours Min. Jan. 10, Year 1952 1 XM 2 □ F Director 59 Yrs DC 213-56-4869 Usual Residence of Decedent show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ₹ Yes 2 □ No Seat Pleasant Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20743 6209 Baltic Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 Divorced 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) filed within Elementary/Seconday (0-12) College (1-4 or 5+) 12th Painter Private traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file
Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Charles H. Berry Estelle M. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6209 Baltic Street Patricia Berry - Sister Seat Pleasant, Md. 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 2011 Clinton: Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig ture of Funeral Service Licensee Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Respiratory Failure Medical resulting in death) Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Bilateral Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alcohol Abuse Fungemia 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia Hepatitis C autopsy performed? Yes 2 X No Seizures or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 X Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours aft To the Funeral Discompleted filled in 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) tach MO

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

DHMH 17 Rev 7/2009

1500 Forest Glen Road Silver Spring, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Revistrar's vopatu

Satuam Shah, M.D.

31. Date filed (Month, Day, Year)

FEB 2 3 2011

D68096

February 11, 2011

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day February 20 Physician/ 7:10 p M Banks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick | If Under 1 Year | If Under 24 Hrs | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🕱 F Months 07/2471962 California Director 557-41-3247 48 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No VA Fairfax **Annandale** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a traumatic event, the Medical Examiner must 3906 King Arthur Road 22003 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3
Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U S Government Attorney permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Carolyn Adlfinger John Robert Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Mitnick/executrix 400 S. Maple Ave. Ste 210, Falls Church, VA 22046 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 02/24/2011 Alexandria, Virginia 4 Donation 5 Other (Specify 21. Signature of Funeral Service Lice 22. Name and Address of Facility Advent Funeral Services, 7211 Lee Hwy, Falls Churc 23a. Part 1 Er Part 1. Enjoy the list of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, when follows. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final oul monary Physician/ de disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 🗌 Yes 2/2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ပ္ 1 Finpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. Investigation 2 | No Accident completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital e Funeral I Medical 29a. Certifier 1/Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mpnth, Day, Year) 7092 21201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Komirant, MD 4006. MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 07328 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Victor Bierlair Month 02-19-2011 11:00 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 102 Bayland Drive Unit 5 Harford Havre de Grace 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-31-1933 174-24-3764 1 X M 2 □ F Months Days Hours Min. Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits Maryland Harford Havre de Grace 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Bayland Drive Unit 5 21078 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tyes 2 No If yes, Give Victnam Year or Dates Victnam 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineering Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Auther Bierlair Lisa Delfoss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4-1 102 Bayland Drive Unit 5, Havre de Grace, Maryland Shella Bierlair (wife) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RA Ferris & Co Inc 02-22-2011 WestChester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20Z No 1 ∐Yes 2 🖾 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

physician

the

this certificate

After thi funeral of

within 24 hours after death.

To the Funeral Director: All completely filled in by the fun

Be

Certification: To

Medical

or Attending Physician:

To the Hospital

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be mainled at

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If feen 27 is marked other than "ns any injury or other traumatic event and once.

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

2

Examiner Physician/Medical þ

burial-trans the aftending p use as detached s been signed by the should be detached Completed has been a page ; director.

The law requires that the death certificate be execute

Division of Vital Records, P.O. Box 68760

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No

9 Unknown

25. Was case examiner?		to medica
	2 000	

27. Manner of Death 1 ★Natural

5 Pending investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifie

29d. Date signed, (Month, Day, Year)

30. Name and address of person who completed gause of death (Item 23a) (Type, Print) 10000

31. Date filed (Mo

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician Day 9:30A Gordon Emiel Butler, Jr. 22, FEB. 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Dorchester Cambridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours **X**XM 2□ F 218-48-5522 Director 64 Apr. 11, 1946 MD Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examinar must be notified at Director 1 □Yes 2 No MD Dorchester Rhodesdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21659 United States 5613 Indiantown Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrician I. DuPont 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental <u>eGordon</u> E. Butler, Sr. Clementine Lee other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trat once. Beverly Butler/Spouse 5613 Indiantown Rd., Rhodesdale, MD 21659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brookview Cemetery 02/26/11 Brookview, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 CF5P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ddes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be execuand Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) þ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate performe 2 **N**O 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: , d in by the f 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in I e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

FEB 25

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are-Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Cornelius <u>Butler</u> 2011 7:00 P M <u>February</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Homestead Manor Caroline If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 24, 1932 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Hours Maryland Director 78 212-40-9008 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Caroline Denton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8391 Tuckahoe Road U.S.A. 21629 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) salth and Mental Hygiene. n 27 is marked other than er traumatic event, the M Elementary/Seconday (0-12) 11 H.S. Grad. College (1-4 or 5+) Farmer Dairy/Food Production Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilbert Perry Butler Hulda Bertha Andrew 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and Department of Healt Important: If item 2 any injury or other t Charlotte Morris 10516 Creston Road, Glen Allen, Virginia 23060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Denton Cemetery Feb. 26, 2011 Denton, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Marland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Non-Sma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Certificate: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. 10 the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) MG 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) te bruary 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAIDYANATHAN 219 S. WASHINGTON ST, EASTON 21601 MD-31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Hannah Crawford 9:20A February 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 708 Crawford Street Oxon Hill Prince Georges 8. Date of Birth (Month, Day, Ye. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours 1 🗆 M 2 🖫 F **Director** 247-60-0391 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 220 and any injury or other traumatic according to the contract of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD PG Oxon Hill 10e. Street and Number 10a. Citizen of What Country? Funeral 708 Crawford Street 20745 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married ☐ Yes 2X No Yes, Give Specify: Black 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Day Care Provider Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Isaac Randolph Sr Annie B. Robin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9346 Pep Rally Lane Waldorf, Md. 20603 Renee Bell-Anderson/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arlington Nat. Cemetery Arlington, VA 22. Name and Address of Facility Hodges & 21. Signature of Funeral Service Licensee Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Endometria Physician/ (ancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or). Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Dire
Completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number Matilda H. D56520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 MERCANTILE MATILDA H LANG LARGO, M.D. 2071 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760,

		For State Registrar		Otato o	i iviai	y laria /		tificate				Cinarii	Reg. No	2011	07332	
Physicia	an	1. Decedent's Name (First,				_						Date of D Month		yYear	3. Time of Death	
/Medic		Clarence Hora										Feb.		Oll Year	6:55 A. M	_
Examin	er	4a. Facility Name (If not inst						4b. City, T		Location	of Death			County of Dea	ath	
		Oakland Nurs: 5. Social Security Number	ing & 1			ter In yrs. last	hirthday)	Oakl		If Under	24 Hrs.	8. Date of B	irth	rrett	rthplace (State or Foreign	
Funeral Director		212-24-2110	1 😾	M 2□F	97		Yrs.		Days	Hours	Min.	Sept .	21, 1	.913 Ma	aryland	
land ow		Usual Residence of Decede 10a. State 10b. Co			10	0c. City, To	own or Loc	ation	 .						10d. Inside City Limits	_
Mary I sh	to	MD Ga:	rrett			0ak1	land								1 ☐ Yes 2 🔀 No	
r 288	Director	10e. Street and Number	-1000				LOTTO	10f. Zip					10g. Cit	izen of What C	ountry?	_
th wit		221 Oakwood	East						215	550				USA		
tems	Funeral	11. Marital Status	1	2. Was Dece Armed Fo	orces?	er in U.S.	13. W	/as Decede Yes, speci	ent of Hi	spanic Or n, Mexica	igin? (Spe n, Puerto I	cify Yes or N Rican, etc.)	lo-	14. Race - Am Black, Whi		
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FEBRUARY 16,2011 CLARK PATTI KAY 10:54PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign May Year 953 Days **Director** 218-64-3243 57 MaryTand Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Directo Maryland Frederick 1 X Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 248 South Carroll Street 21701 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Completed 3 Widowed 4 XDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur Calvin Snoots Juanita Janet Payne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn E. Rice / Companion 248 South Carroll Street, Frederick, MD 21701 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) Olivet Cemetery 2/21/2011 Frederick, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21 Eut 2. 23a, Part 1. Enter the disease, or acations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. orongry Wisease disease or condition Medical resulting in death) Due to (or as a consequence of): Examine months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami and I-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe certificate 2 🗌 No Yes 2 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1X Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b, Signature and title of cert 29d. Date signed (Month, Day, Year) 36421 merena Name and address of person who completed cause of death (Item 23a) (Type, Print) #104 Frederick 9093 James ette 32. Registrar's Signature State Registrar

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Od Date filed (Menth Day Voor) 20 Pagistrar's Signature				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
Registrar FEB 2 2 2011					borch (action)		,,,,,	-21401

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FIELD AUARY William Ralph Coulbourne, Sr. 11:00 A-M Medical 4c. County of Peath 4a. Facility Name (if not institution, give street and number) 4b. City. Town Examiner MARYLAND HEALTH CARE SYSTEM 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 🛛 M 2 ☐ F **Funeral** (Month, Day, Months Year Director 216-48-5046 64 1947 MD Tan Usual Residence of Decedent 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Hurlock 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21643 4842 Skinners Run Road United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 6 Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced 68-70 Specify: Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Contractor Carpenter 10 Be 18. Mother's Name (First, Middle, Maiden S Esther Griffith 17. Father's Name (First, Middle, Last) Charles W. Coulbourne, Sr. permit. Page 1 and 2 should be to Department of Health and Ments Important: If item 27 is marked any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4842 Skinners Run Rd., Hurlock, MD 21643 Connie Coulbourne/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State Eastern Shore Veterans Cent 02/22/11 Hurlock, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, M. 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final UNKNOWN Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month 1 Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗀 No Yes 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗖 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD-072692h DEBORAH BULLOCK MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 VA 32. Registrar's Signature State Registrar FFR

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			For State Registrar	State of Ma	ai yiai iu	•	rtificate of				Reg. No.	JII	0/33	36
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	Examin	er	4a. Facility Name (If not institution, Homewood at Wil				4b. City, Town, o					ounty of Death		
**	Funeral				e (In yrs. las	t birthday)	William If Under 1 Year	If Under		8. Date of Birth		shingto 9. Birth	place (State or I	Foreign
	Director		218-24-9246	1□M 2\\ F	8	1 Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day)6/26/1	929	P.		
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						0d. Inside City	Limits
	Maryli f sho	lor	MD Washing	rton		iamsp							1 □Yes 2	X No
	the r	rec	10e. Street and Number	,	MITI	Lamsp	10f. Zip Code				10g. Citizer	n of What Cou	ntry?	
	h with	Funeral Director	16505 Virginia	Avenue			2179	95			USA			
	ems	uner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decedent of H	lispanic Or an, Mexica	rigin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14.	. Race - Ameri Black, White,		
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it Morker Examinations in the confinence of the confin	by	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:	No		1∐Yes 2M∏No	Specify				pecify: Whi	ite	
2 C	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	1	(Give	dent's Usual Occup kind of work done	during mos	st of workin	g	16b. Kind	of Business/In	dustry	
7	vithin ene. than	du	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Cook	DO NOT use retired	d)			Rec	taurant	-	
7 0	filed v Hygie other i		17. Father's Name (First, Middle, La	ust)		COOK		18. Moth	er's Name	(First, Middle,			-	
yland	Ild be fental rked c	To Be	Richard Bishop					Add	ie Sm	ith				
ary	shou and M s mar		19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Street				r, City or T	own, State, Zi	o Code)	
e, ma	es 1 and 2 of Health of item 27 is r other tra		Shirley Cubbage	/Niece			Resley Ro				21750			
9	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐ Removal from State	20b. Plac	e of Dispo etery, crer	sition (Name of natory or other plac	ce)	Da	ate	20c. Loca	tion - City or To	own, State	
Бапптог	it. Pag rtmen rtant: njury	10	4 ☐ Donation 5 ☐ Other (Spe	cify)	Smitl		g Cremato						The second secon	
g	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral 100 in end	-nu	M00260							in Str		
			23a. Part 1. Enter the disease, or c shock, or heart failure. List or				rove Fune erthe mode of dyin					MD 21/	Approximate/ Interval Between	een
-	Physician	1	Immediate Cause (Final disease or condition	ny one cause on each in	GAG	K(-						i	Onset and be	ath /
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	ice of):							<u> </u>	
	Cxamme	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequer	ce of).								
	uted	Examiner	Cause (Disease or injury that initiated events		a consequer	100 017.								
ב ב	an and rial-tra	Exa	resulting in death) Last	c Due to (or as	a consequer	ice of):								
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Š	± 5.42		IF FEMALE:	23c. If yes, outcome	of pregnance	v						d D-46 d-15		
X D D	leath atten	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	У			230	d. Date of delive Month	Pery Day Ye	ar
S	t the c by the achec	hysi	9 Unknown	9 🗌 Unknown										
ν̂	es tha gned se det	by P	Part II. Oth sonificant condition		ut not resultir	ng in the	erlying cause giv	en in Part	I.		/	-	the cause of dea	
ecoras,	equir	ted	Typeteren	(0,00 1)	PASTE	07 1	The contract of the	4		1 🗆 Y	es 21	No 3☐ Pro	bably 4 ☐ Un	known
ပ် မ	ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Completed	14PE C							24a. Was a autop perfor	sy	24b. Were aut prior to co death?	opsy findings av ompletion of cau	railable use of
N I Call	in: Th		25. Was case referred to medical					ne Plac	a of Dooth	1 □Yes (Check only or	2 No	1 □Yes	2 □No	
>	ysicia is cert directe	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2□EP	l/Outpatier	nt 3 DOA Oth			ne 5 ☐ Resid		Other (Spec	ifv)	
ō	ng Ph ter thi	T:U	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	iry 28	Bb. Time o		ry_at		28d. Describe h			-37	
VISION	tendir eath. or: A the fu	catio	2 Accident investiga 3 Suicide 6 Could no	the				lYes 2□						
5	lor At after d Direct J in by	Certification:	4 ☐ Homicide determin		ury - At home c. <i>(Specify)</i>	e, farm, str	eet, factory, office		2	28f. Location (S City or Tow	itreet and I m, State)	Number or Rui	al Route Numbe	9r,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C		Physician: To the best caminer: On the basis of and manner st	f examination									
	To the within To the comple	Me	29b. Signature and title by certifier	and marinet se	X		29c. Lisens	se number		:	29d. Date :	signed (Month	Day, Year)	
1			1 WEST	WEDICAL	- Det	CTIV	()	1700	5		71	12/120	2/1	
			30. Name and address of person w	no completed cause of d	eath (Item 2	3a) (Type,	PTTT /	(-	16	, II.	1	21:0	111/5	13.
			31. Date filed (Month, Day, Year)	TONEY MI	ar's Signatur	7545	1athe	11	E/0	1/1/2	KAS R	eur (W D [[155
	Sta Registr		MAR 0 8 2011 4	neva A	ar's Signatur									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Febru Physician/ IRIS N/M/NCRUZ Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Plata a 1/0 **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 086-24-1753 1 - M 2 12 F 85 Hours 1 1 -5 - 1 9 2 5 PUERTO RICO Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County the Maryland 10d. Inside City Limits Director MD. CHARLES BRANDYWINE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 18210 CLOVE PLACE 20613 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 Yes 2 □ No Specify. Specify: WHITE 3 ¥ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th SEAMSTRESS GARMENT and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed to Department of Health and Mental Hyg Important: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ GERMAN SANCHEZ JULIA ARROYO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALAIDA RODRIGUEZ-DAUGHTER injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State QUEEN OF ALL SAINTS 3-5-11 CENTRAL ISLIP, NY 4 ☐ Donation 5 ☐ Other (Specify) Signature of Juneral Service Licenses 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner ONIM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknow Month Dav Year Pregnant at time of death Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 : certificate has autopsy performed 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) မ Other: 1 Yes 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manuter of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 2 No Accident Investigation 24 hours after deatle Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exam ver: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nu Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date sig 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terence Bertele MD, 12070 Old Line (A ine Center Suite 303 Waldorf MD 20602 Date filed (Month, Dav. Registrar's Signature State MAR 0 8 2011 Registrar

DHMH 17 Rev 7/2009

VOID

CERTIFICATE

2011 - 07338

SEE

CERTIFICATE

2011-04487

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Nora E. Dollymore 0/27/11/2019 2:45A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 1 - M 2 - F (Month, Day, Year) 579 22 3446 Director 04/02/1923 Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2840 Newlands Street, NW 20015 United States e 1 and 2 should be filed within 12 nows.
t of Health and Mental Hyglene.
If item 27 is marked other than "natural", or item
If item 27 is marked other than "natural", or item 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ US Government Economist any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Patrick J. Dollymore Anna Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Flaherty/Niece 6319 Ema Court Elkridge, MD 21075 #imore, | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 1XI Burial 2 🗌 Cremation 3 🗌 Removal from State Mt. Olivet Cemetery 02/19/2011 Washington, DC Important; 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. Signature of Furieral Sent 5130 Wisconsin Ave., NW Washington, DC 20016 23a. Part 1. Enter the disease, or or implications that c.u. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsass or impury that initiated assets) Examine Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknowr been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No 1 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 24 hours after death. Funeral Director: A Accident
Suicide 2 No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar DHMH 17 Rev 7/2009

State

To the I within 2

29b. Signature and title of

31. Date filed (Month, Day, Year)

FEB 17

na 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O.

Division of Vital

Aruna Paspula MD 18101 Prince Philip Drive #427 Olney, MD 20832

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Barbara Duva11 а м Annette February 2011 1:35 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 14605 Dowling Drive Montgomery Burtonsville 7. Age (In yrs. last birthday) Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Country) MI Min. 1 M 2 K F Dec. Jay, Year 920 90 Director 577-22-8014 Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Burtonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14605 Dowling Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. "natural", Completed 3 ☑ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Health Dept. Screening Tech traumatic event, Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve and Mental I ပ Cecil Bangham Edna Cora Squires 19a, Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14605 Dowling Drive, Burtonsville, MD 20866 John Edward Duvall/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Feb. 24, Union Cemetery 4 Donation 5 Other (Specify) Burtonsville, MD of Funeral Service License P22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University BLvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) End-Stage Dementia 10 yrs Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and stransit street burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months? Month Day Pregnant at time of death Yes 2 X No signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed? Hospital or Attending Physician: The this certificate 1 Yes 2 No of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 🔯 No ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred : After (Month, Day, Year) 1 🔀 Natural 5 Pending Division death. 1 Yes Accident Investigation n 24 hours after deat e Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) R098788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Tech la

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32 Registrar's Signature

Danken

18

31. Date filed (Month, Day, Year)

#240 Silver Spring, Md.

0731.1

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it at M-dical Examination any injury or other traumatic event, it at M-dical Examination and once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		Registrar				Cer	tificate of t	Jeath		Reg. No.	.011	0/04	1
nysici: Medic		1. Decedent's Name (Fit Margare		ist) DiPonziano)				2. Date of De Month Feb 17		Year	3. Time of Death 5:53 A	Λ
xamin neral		4a. Facility Name (If not Sunrise Asst. 5. Social Security Number 197 16 9795	Living		mber) 7. Age (In yrs. 103	last birthday) Yrs.	4b. City, Town, or Annapoli. If Under 1 Year Months Days	S If Under 24 Hrs. Hours Min.	8. Date of Bi	4c. Ce	Cot	e1 nplace (State or Foreig untry)	n
Show dat	ı		o. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limit	
or 28a-f	Director	Maryland 10e. Street and Number				Riva	10f. Zip Code			10g. Citize	n of What Cou	1 □ Yes 2 □ N untry?	
18 23a	Funeral		7 Shrews	bury Lane	edent Ever in U.	Q 12 \	21140	ispanic Origin? (Sp	ecify Ves or N		nited St		
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z/ is m r traum		19a. Informant's Name/I	, ,	(Type. Print) (daughte:	r)		-	and Number or Run Cy Lane, Riv		-	own, State, Z	üp Code)	
or othe		20a. Method of Dispositi	ion		20b. F		sition (Name of natory or other plac		Date		ition - City or T	own, State	
ortant: injury o		4 □ Donation 5 □	Other (Special	fy)	Ce		Cemetery Name and Address	Feb 25	5, 2011 Europeal	Suitla	and, MD	Old Alexandr	_
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ician dical		23 Far 1. Enter the dishock, or heart fail Immediate Cause (Final disease or condition resulting in death)	lure. List only	one cause on e	each line.	lac	111	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
use as the burial-transit	ical Examiner	Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ons, Justing g y	C	(or as a conseq								
ached for use as th	by Physician/Medical	IF FEMALE: 23b. Was decedent precin the past 12 month 1 □ Yes 2 Moo 9 □ Unknown	ths?	1 Live	tcome of pregna birth 2 Feta nant at time of c	Ideath 3 ⊑	Ectopic pregnance	у		23	d. Date of deli Month	very Day Year	
d be det	l by P	Part II. Other significant	t conditions	contributing to d	- 1h	ulting in the ur	nderlying cause give	en in Part I.		tobacco use Yes 2 🌌	_	the cause of death?	'n
completely filled in by the funeral director, page 2 should be detached for	Completed		De	he .					24a. Was	an psy ormed	24b. Were aut prior to c death?	topsy findings available ompletion of cause of	le
ector, p	BeC	25. Was case referred to examiner?	o medical	Hospital:			Oth	26. Place of Deatl	h (Check only	one)		Alega II. c	
funeral dir	tion: To		☐ Pending investigation	28a. Date	Inpatient 2 of Injury th, Day, Year)	28b. Time of Injury	28c. Injury Work	y at	me 5 Res 28d. Describe			wy wy	
d in by the	Certification: To	2 Accident 3 Suicide 6 [4 Homicide	Could not b	e 28e. Place	of Injury - At hong, etc. (Specif	ome, farm, stre	eet, factory, office			Street and i wn, State)	Number or Ru	ral Route Number,	
pletely fille	Medical C	29a. Certifier (Check only one)	Certifying Ph Medical Exam	miner: On the b	e best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	e cause(s) a , date and p	nd manner as lace, and due	stated. to the cause(s)	
t moo	M	29b. Signature and title	of certifier				29c. License	number 70 28		29d. Date:	signed (Month	, Day, Year) 1201/	
3		30. Name and addless of HULLICA	the	Dra	Ce WX	jaa	ely Ac	reste 2	3/ An	napa	elis vi	MD2140	1
Stat egistra		31. Date filed (Month, Da	EB 23		legistrar's Signa	A. Jy	John Sold		,	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla State Registrar		rtment of			giene Reg. N2 0 1 1	07342	
	Physicia		1. Decedent's Name (First, Middle, Last) Eloise Chrystal Davis				2. Date of Dea Month Februc	ath	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give street and number) Memorial Hospital		4b. City, Town, o	917	Death	4c. County of Deat	11	
	Funeral Director		5. Social Security Number $100-36-5086$ 6. Sex $1 \square M \ 2 \ X = 90$	rs. last birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date of Birt 0/1/0/10/2019	Parth 9. Birthplace (State or Foreign Country) NY		
•	/land f show ed at	tor	MIX I -	City, Town or Loc	ation				10d. Inside City Limits	
	the Mary or 28a-	Director	10e. Street and Number	Ridgely	10f. Zip Code			10g. Citizen of What Co	1 ☐ Yes 2 🛣 No	
	ath with	Funeral	11275 Central Avenue 11. Marital Status 12. Was Decedent Ever in	U.S. 13. W	2166		? (Specify Yes or No-	USA 14. Race - Ame	rican Indian	
9600	urs after de tural", or ite al Examine	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	☐ Yes 2 No	o Specify:	? (Specify Yes or No- puerto Rican, etc.)	Black, White Specify: Cau	e, etc.	
Eloise Davis Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 12 ITS Grad College (1-4 or 5+)	(China to	ent's Usual Occu ind of work done O NOT use retired Postal	during most of	f working	US Post Of		
Davis ryland 2	should be filed within and Mental Hygiene. is marked other tha aumatic event, the h	To Be	17. Father's Name (First, Middle, Last) Willis Oliver Penney				s Name <i>(First, Middl</i> e, othy Edna '			
se L Mary	and 2 should Health and M em 27 is mar ther traumat		19a. Informant's Name/Relationship (Type, Print) Penney Smith				or Rural Route Number , Ridgely,	r, City or Town, State, Zij MD 21660	o Code)	
Eloise timore,	Page 1 an ment of He ant: If iten ury or oth		1 Burial 2 Cremation 3 Bemoval from State	b. Place of Dispos cemetery, crem Capitol (atory or other pla	y 2/	'27/2011	20c. Location - City or Dover, DE	Town, State	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Liveragee	Mic Mic	Name and Addre OORE Funer	ess of Facility al Home,	PA, 12 S. 2nd	l St., Denton,	MD 21629	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequentially list conditions,	MYO	r the mode of dyi		rdiac or respiratory arr		Approximate Interval Between Onset and Death	
09	cate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a cons c. Due to (or as a cons d.					!		
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phytompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of prediction in the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnan Other (specify)	icy		23d. Date of de Month	livery Day Year	
ds, P.O	quires that t en signed b uld be deta	ا ۾	Part II. Other significant conditions contributing to death but not	resulting in the un	nderlying cause g	iven in Part I.		obacco use contribute to Yes 2 No 3 P	the cause of death?	
Recor	: The law rec cate has bee , page 2 sho	Completed					24a. Was a autop perfo	osy prior to death?	topsy findings available completion of cause of s 2 No	
Vital	nysician: iis certific director,		25. Was case referred to medical examiner? 1 Yes 2 10 10 Hospital: 1 Patient 2	☐ ER/Outpatient	Lou	ner:	(Check only one)	lence 6 🗆 Other (Spec	ify)	
on of	anding Prath.	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation 28a. Date of injury (Month, Day, Year,	28b. Time of injury	28c. Inju wor M 1			ow injury occurred		
Divisi	al or Atte s after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, stre- cify)	et, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,	
	the Hospit in 24 hour the Funera	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn (2 Medical Examiner: On the basis of examinar only one) 3 Certifying Nurse Practioner: To the best of	ation and/or investi-	gation, in my opin	ion, death occu	rred at the time, date a	nd place, and due to the	cause(s) and manner stated.	
	Tot Vith		29b. Signature and title of certifier **Parents** **HD********************************		29c, Licens	o 066	1	29d. Date signed (Month		
				IS WAS	H12476	TZ NO	EASTO	~ MD		
	Stat Registra	~	31. Date filed (Month, Day, Year) 42. Registrar's Sig	in fure	the state of the s					

DHMH 17 Rev 7/2009

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Registrar DHMH 17 Rev 1/2001 OCME 2006

State

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Pamela E. Southall, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

February 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FERMIANS 21, 5:34 AM Arnold Dufis Enfusse Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington County Meritus Medical Center Hagers town If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 407-54-0451 Months Days Jan. 6, 1940 1 XM 2 - F 71 Kentucky **Director** Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Smithsburg 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14244 Windy Haven Rd. 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Xyes 2 No.58If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, . or 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Divorced 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Signal Officer Department of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roy Enfusse Vivian Fields Enfusse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14244 Windy Haven Rd. Smithsburg, MD 21783 Doris Enfusse-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Cemetery 2-24-2011 |Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and -tran that initiated events Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year ed by the a detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 N 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No Hospita Other: 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how Injury occurred 5 \square Pending Natural s after death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the Hosp within 24 hor To the Fune completed fi Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifin 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25144+1 Maha MI 520

DHMH 17 Rev 7/2009

State Registrar 24

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 13 2011 11:06 AM Andrew Martin Fantacci Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) av 7 1953 1 XM 2 □ F Months Days Hours Washington, DC 57 **Director** 212-64-3675 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a18221 Mulberry Court 20877 USA Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Motion Picture Film Printer Film. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last ည antacei, Louis A. Fantacci Reta Nuce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine J. Fantacci/Spouse 18221 Mulberry Court, Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State permit. Page any injury or 4 Donation 5 Other (Specify) Metropolitan Crem. 02/16/2011 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home M= Millian MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Return shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of The law requires that the death certificate be executed the burial transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 g 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Division of Vital pompleted filled in by the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After ! Natural Accident 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: Investigation 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Gertifying Nurse Pranticiper To the bist of my knowledge, dieth oncum id at the filme, data and place, and thus to the cause(s) and marker as stated 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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9901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

2. Registrar's Sign

Kalaria

31. Date filed (Month, Day, Year)

1) 000 64068

Medical dtr.

Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ 2011 4:00 Dorothy Lorraine Farri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert County Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours Days 08/12/1930 1 M 2 X F DC Director 579-36-0916 80 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🗓 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 8851 Stratford Court 20736 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No If Yes, Give Specify Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education Aid Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Cook James Wald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8851 Stratford Court, Owings, MD 20736 Page 1 and 2 s Joe Farri / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o oţ 1 X Burial 2 Cremation 3 Removal from State 02/24/2011 Resurrection Cemetery Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Signature of Funeral Service Licensee Gazy J. 8125 Southern Maryland Blvd., Owings, MD 20736 Coff 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on ine Ogset and Death Immediate Cause (Final months Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Year Pregnant at time of death 5 Other (specify) g 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? has certificate 1 Yes 2 No after death.

Director: After this certification by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury Accident 5 Pending 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29d. Date Prince Frederick 0 05 32. Registra

State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PERMARY Paul Eugene FRITZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Clear Spring 14013 Fairview Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Ye 1 🗶 M 2 🗆 F Hours Pennsylvania Director 64 1946 Aug 169-38-5257 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Clear Spring Washington Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21722 USA 14013 Fairview Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 X Married 1 Yes 2 No 3 Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Bernice Jane Keebaugh Paul Calvin Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14013 Fairview Road, Clear Spring, Maryland 21722 Marsha Fritz - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State Hagerstown, Maryland Cedar Lawn Mem. Park 2/28/2011 4 Donation 5 Other (Specify) Minnich Funeral Home 22. Name and Address of Facility 21. Signature of Eunoral Service Licenses Hagerstown, Md. 21740 415 E. Wilson Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final ₽trysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician. The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death 2 🗆 No signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 \sum Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Doth 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes death. n 24 hours after death e Funeral Director; A bleted filled in by the fi Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death assumed at the time. Medical 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-6 Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:14 Vicki, Furgneve a5 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Cloversity of Maryland Medical nenter City Baltimore Social Security Number 212–80–3998 If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (*ln yr*s. **49 Funeral** OCT th, Day 8 1 🗌 M 2 🔀 F Davs Months °°1961 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frostburg Allegany MD 1XXYes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral United States 20201 Merriman St. 21532 Page 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc.
white "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced is marked other than "natu aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Medical Secretary æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Shingler Evelyn Westfall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
226 Smoot St, Westernport, Maryland 21562 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shu Department of Health an Important: If item 27 is any injury or other trau once. Victoria Fairgrieve/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Frostburg Mem. Park 03/02/2011 20c. Location - City or Town, State 1 🔀 Burlal 2 🗌 Cremation 3 🔲 Removal from State Frostburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home han na 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Preumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit that initiated events Due to (or as a consequence of): the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 es 2 No Por Month Pregnant at time of death 5 Other (specify) Day Year signed by the a g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manue of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the func Natural 5 Pending 1 Tes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb. 26, 2011 M P24354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Norsworthy 22 South Greene Street, Baltimore, MD 2/201 31. Date filed (Month, Day Year) FEB 2 8 2011 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 18, Charles Frank 2011 1:00 Foster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Perryville Cecil 1745 Perryville Road 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219-42-2185 1 ▼ M 2 □ F Hours Feb. 23 Year 1944 Country) vland 66 Director Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a Maryland Perryville 1 🗌 Yes 2 😾 No Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21903 U.S.A. 1745 Perryville Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter ledical Examiner r Armed Force Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: Specify: 3 😾 Widowed 4 🗆 Divorced Completed White Year or Dates 27 is marked other than "natur traumatic event, the Medical 16b. Kind of Business Industry Cytec Industries, Inc. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Two Years Elementary/Seconday (0-12) Havre de Grace, Maryland Lab Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth Richardson Rufus Allen Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1745 Perryville Road, Perryville, Maryland 21903 Kimberly Craig (daughter) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State West Chester. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State R.A.Ferris & Co., Inc. 02/20/11 Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P Reserved 11e. Maryland 21903-0766 21. Signature of Funeral Service Lisensee Hatterson, Sr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA DAYS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASPERGILLOSIS YEARS PULLHOWART Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant Pregnant at time of death 5 Other (specify) 1 L Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEPENDANT DIABETES 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: Other: 욘

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760 cate has been signed by the a page 2 should be detached certificate

After this

24 hours after deat Funeral Director: filled in by the

within 24 ho

To the Fune

completed fi

Certificate:

Medical

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

FEBRUARY

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occur? Medical Examiner: On the basis of examination and/or investigation. Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
29b. Signature ar	nd title of certifier	29c. License number	29d. Date signed (Month. Day, Year)

D0047711

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

determined

Suite ELLTON MAKY LAND GAR-EC Strect 304-306 North 31. Date filed (Month, Day, Year) FEB 2 3 2011

State Registrar

11-01532	٠
Robert Gaver	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2011 07350

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Funeral Director		5. Social Security Number 215-44-7579	6. Sex		Age (In yrs. la	Months Days Hours Min.								44	Foreign	nplace (State or ntryMary land
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "astural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director			arried 1 orced If Ye	. Was Decede Armed Force Y Yes es, Give Year Dates:	es? 2 No 64-68		If Yes,	specif es 2	y Cubar	specify:	, Puerto R	cify Yes or No- tican, etc.)		White Specify:	, etc. Vhit	
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Programment of the past of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1/2 Certifying Nurse Practioner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) M.A. Mavanur M.D. 18101 Prince Philip Dr. Olney, Md 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ires that signed I	d by					ulting in the u	nderlying cause	given in Part I.				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.A. Mavanur M.D. 18101 Prince Philip Dr. Olney, Md 20832 State 31. Date filed (Month, Day, Year) 34. Registrar's Signature	tal or Al				28e. Place of Inj	ury - At ho c. (Specify,	me, farm, stre	et, fact o ry, offic	е				Rural Route Number,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.A. Mavanur M.D. 18101 Prince Philip Dr. Olney, Md 20832 State 31. Date filed (Month, Day, Year) 34. Registrar's Signature	vithin To the	2	29b. Signature and	title of certifier		best of my	Knowledge, C			lace, and due to t			
M.A.Mavanur M.D. 18101 Prince Philip Dr. Olney, Md 20832 State 31. Date filed (Month, Day, Year) 34. Registrar's Signature	-								071314		2	10/20	1)
State 31. Date filed (Month, Day, Year) 3f. Registrar's Signature			30. Name and addre	ess of person wh • Mavanu	or completed cause of	leath (Item B 1 0 1	23a) (Type, P Prin	rint) Ce Phi	lip Dr.	Olne	y,Mc	L 2083	.2
			31. Date filed (Monti	h, Day, Year)	3. Registr			d)			, ,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) ^{Day} 2011 Physician/ Robert Arnold Gates Feb. 4:30 p M 14, Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year) April 3, 1928 **Funeral** Days Min Country) 1 ₺ M 2 🗆 F Months D.C. 82 Yrs. Director 577-34-9419 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State the Maryland Director 1 Yes 2 1. No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a o edical Examiner must be Funeral USA 20904 4 David Court hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11 Marital Status Black, White, etc. Armed Forces þ 1 Never Married 21 Married 1
¥ Yes 2 □ No Specify White Maryland 21215-0036 1 ☐ Yes 2 No Specify: Year or Dates. 1.946-47 3 Widowed 4 Divorced Completed and Mental Hygiene.
is marked other than "natural raumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Manufacturing Manufacturer Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be fi. f Health and Mental item 27 is marked Margaret Brown William Gates traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4 David Court, Silver Spring, MD 20904 Delores Elizabeth Gates/Wife permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Feb. 2011 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 18, Adelphi, MD George Cemeter Von 21. Signature of Funeral Service Licenses 22 Name and Address of Eachly Ins Funeral Home Inc. oseph P. 1401503 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiogenic Shock Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Cardiac Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and "completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Peripheral Artery Disease, Coronary Artery Disease, Division of Vital Records, 1 Yes 2 No 3 Probably 4 Tunknown Completed is certificate has been sidirector, page 2 should l 24b. Were autopsy findings available 24a. Was an COPD autopsy performed? prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 🖳 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X 7-No ပ္ 1 🎦 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending **X**∑ Natural work 1 Yes 2 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Feb. 14, 2011 D66249

State Registrar 1500 Forest Glen Road, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Jonathan Duran,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}8, Bertha Vera Garner 7:50 P February 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert 550 Garner Road Lusby 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 X F 08-04-1925 Mary I and Director 220-18-8691 85 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Calvert Lusby 1 Yes 2 X No 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 550 Garner Road 20657 United States within 72 hours after death with 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumastic. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Postal Worker Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Edward Christian Rodey Anna Mae Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vaterie Garner - Daughter 550 Garner Road, Lusby, Maryland 20657 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State St. Paul UMC Cemetery 2-24-2011 Lusby, Maryland 4 Donation 5 Other (Specify) Rausch Funeral Home, P. A. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death rebroveson Physician disease or condition resulting in death) noith Medical Due to (or as a consequence of): Examiner 3 months ante sonan Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami and trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No or Attending Physician: The law requires that the death Pregnant at time of death the g Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No this certificate has page 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours atter uccom.

To the Funeral Director: After 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 21, 2011 25186 Bennellas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW Charles W. Bennett, MD 11845 H. G. Trueman Road, Lusby, Maryland 20657

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07355 State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 12, 2011 Physician/ 9:10 a M James Hutchison, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 404 Highgate Terrace If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ♣M 2 ☐ F Months Days Hours Min. sept. Day Year) 1926 KS 84 Director 515-12-4616 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Silver Spring Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral 20904 USA 404 Highgate Terrace 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1

 Yes, Give
Year or Dates.
1943-45 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black and Mental Hygiene. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working (Specify only highest grade completed) Director of the Office of Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Federal <u> Historically Black Colleges</u> <u>Government</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Alyce Rosavelt Jolly Ira James Hutchison, Sr. 1 and 2 should b of Health and Mer item 27 is mark other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Highgate Terrace, Silver Spring, MD 20904 404 Patricia A. Hutchison/Wife Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Febate 18. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Silver Spring, MD Gate of Heaven Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20901 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ hronic Medical resulting in death) Due to (or as a consequence of): **Examiner** SEASE years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a correquence of): use as the burial-transi Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be ex signed by the attending physician d be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy☐ Other (specify) ____ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 X Yes 2 No 3 Probably 4 Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 Nio 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) မ 28c. Injury at work?
1 Yes 2 No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: (Month, Day, Year) injury 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the 29b. Signature and title of certifier 29c, License number 0 Name and address of person who completed cause of death (Item 23a) (Type 1 Clat 32 Registrar's Sign 31, Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State C Registrar	-	Certificate of Death		eg. No. 2011	07356
Г	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	h Day Xear	3. Time of Death
	Medic	al .	James William HARDY 4a. Facility Name (if not institution, give street and nun	cherl	4b. City, Town, or Location		4c, County of Death	215 pm
	Examin	er	20434 Jefferson Blvd.	1501)	Hagersto			ington
	Funeral		5. Social Security Number 6. Sex 1 M 2 F	7. Age (In yrs. last birthda	ay) If Under 1 Year If Under	24 Hrs. 8 Date of Birth	9. Birth	place (State or Foreign
	Director		219-07-9706 Usual Residence of Decedent	89 Yrs	S.	Min. (Month, Day, Feb. 10	6 1922 Mar	yland
	and Show Lat	o	10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
	Maryk 28a-f	Director	Maryland Washington	Hager	stown			1 X Yes 2 □ No
	h the	al Di	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Coul	ntry?
	ith wit	Funeral	20434 Jefferson Blvd. 11. Marital Status 12. Was Dece	edent Ever in U.S.	21742	igin? (Specify Ves or No-	USA 14. Race - Americ	ran Indian
0	er dez or ite miner	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☒ Yes	2 □ No	13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexical		Black, White,	
ĕ	urs aft ural", I Exar	ted t	3 ☒ Widowed 4 ☐ Divorced If Yes, Giv	ve WW II	1 ☐ Yes 2 🖾 No Specify	···	Specify: W	hite
5	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) (G	ecedent's Usual Occupation Rive kind of work done during mos e. DO NOT use retired)	st of working	16b. Kind of Business In	dustry
21215-0036	e filed within 72 hours after death with the Maryland at hygiene. A plygiene at hygiene and either than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		Elementary/Seconday (0-12) College (1	-4 or 5+)	Electrician		Cement Mf	g.
g	ould be filed wit d Mental Hygie marked other matic event, #	Be c	17. Father's Name (First, Middle, Last)			ner's Name (First, Middle, N	- /	
yla	uld be Menta narked natic e	욘	Rudolph Hardy			na Belle Mar	-	
Maryland	2 should th and Mr 27 is mar traumati		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street and Numb 010 Warrenfeltz			
	1 and 2 s f Health item 27 other tr		Yvonne Wilson - Daughte 20a. Method of Disposition	20b, Place of D	isposition (Name of		20c. Location - City or To	
E	Page 1 ment of ant: If if ury or c		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	1 State	crematory or other place) Lawn Mem. Park	2/28/2011	Hagerstown,	Maryland
Baltimore,	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.	i	21. Signature of Funeral Service Licens	10	22. Name and Address of Facili	ity Minnich F	uneral Home	
ш	ă∆ ⊑ ≅ ठ		23a. Part 1. Enter the disease, or complications that	me	415 E. Wilson			
			shock, or heart failure. List only one cause on ea Immediate Cause (Final	ach line.	enter the mode of dying, such as	s cardiac or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician/ Medical	M	disease or condition	(or as a sequence of):	e Herri Pa	Time		y wes
ممسو	Examiner		Sequentially list conditions,	Dilated	Cardionny	opathy		3 mond
	d Sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iiniury	(or as a consequence of):	line mano	ha		3 more
	ecute and al-trans	Exar	that initiated events C.	(or as a consequence of):	une forte	7 - 71		7
0	icate be executed physician and s the burial-transit	ledical	d	assATC	slenosis	7		Years!
68760	S 2 S	Med	IF FEMALE:		77.			1
Box 6	death certific he attending ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	tcome of pregnancy Birth 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive	very Day Year
 	g 9 9	hysic	1 Yes 2 No 4 Pret 9 Unknown 9 Unk		other (specify)			
P.O.	requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to c	death but not resulting in t	the underlying cause given in Part		pacco use contribute to t	
ds,	quires en sig ould b	ted	anal	-0581/100	un	1 □ Y	és 2 □ No 3 □ Pro	bably 4 Unknown
200	law re has be e 2 sh	Completed	Dalele	se me	Witus	24a. Was a autops	prior to co	opsy findings available ompletion of cause of
Be	sician: The law certificate has rector, page 2 a		25. Was case referred to medical		00.20	1 🗆 Yes	2 No 1 ☐ Yes	2 □ No
/ita	Physician: Tr this certifice	To Be	examiner? Hospital:	Inpatient 2 ER/Outp	Other:	ath (Check only one) Nursing Home 5 Reside	ence 6 Other (Specif	<u> </u>
of o	ding Phy th. After this funeral o		27. Manner of Death 28a. Date		ne of 28c. Injury at		ow injury occurred	<u> </u>
g	or Attendir fter death. irector: Af in by th∈ fu	Certificate:	2 Accident Investigation		M 1 Tes 2			
Division of Vital Records,		Cert	4 Lieminide determined 286, Place	e of Injury - At home, farm ling, etc. (Specify)	i, street, factory, office	28f. Location (St City or Town	reet and Number or Rura n, State)	! Houte Number,
Ω	Hospital or 24 hours afte Funeral Dir eted filled in	Medical	29a. Certifier 1 Certifying Physician: To the	best of my knowledge, de	ath occured at the time, date and	place, and due to the cau	se(s) and manner as stat	ed.
	To the Hosl within 24 ho To the Fune completed t	Med	Only Briel 3 Certifying Nurse Practioner	Sis of examination and/or i	1	te and plans, and dust to the	cause s and manner as s	stated.
	No.		29b. Signature and title of certifier		29c. License number	96	29d. Date signed (Month, Fehman 2	5, 20/1
			30. Name and address of person who completed cau	ise of death (Item 23a) (Ty	pe, Print)	ane Rd 1	from chan in	n 21712
10	4-6+1		21 Data filed Man Town	MU Sirest	10311 off	०१७ ० म	-001 -00 (1)	לוויי
	Sta Registra		31. Date filed (Mon FEBY 2 2011 32.	egistrar's Signature	par			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2 Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 12:10 PM 2011 L. February Hutton Thelma Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. **Funeral** Days (Month, Day, Year) Washington. Months Hours 215-38-4135 1 🗆 M 2 🗶 F Director Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20877 United States Funeral 17654 Amity Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give þ 1 Never Married 2 X Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 72 lath and Mental Hygiene.
27 is marked other than "r r traumatic event, the Med College (1-4 or 5+) Elementary/Seconday (0-12) Radiology Technician Medical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Jackson ပ Lloyd Chase of Health and Mer of Health and Mer fitem 27 is mark rother traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gaithersburg, Md 20886 18321 Lost Knife Circle Hutton / Son Keith Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Fort Lincoln Cemetery 2/26/2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee Brentwood, Md 20722 3401 Bladensburg Road rances se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Part 1. Enter the dis shock, or heart fature. List only one cause on each line.

Immediate Cause (Final disease or condition ____a ___Cardiac Onset and Death Pnysician Cardiac Arrest Medical resulting in death) Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Dementia and burial-tran Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Diabetes Box 68760 as the IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Day Year ξ Pregnant at time of death 5 Other (specify) detached g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 K No 2 🗆 No To the Hospital or Attending Physician: The certificate 1 Tyes Yes 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: After injury w<u>or</u>k? 1 🖺 Natural 5 Pending 1 ☐ Yes 2 ☐ No М within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide building, etc. (Specify) City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0032247 2.17. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Rd Silver Spring, Md

Registrar

DHMH 17 Rev 7/2009

State

Nooshin Farr, M.D.

31. Date filed (Month, Day, Year)

FFR 2 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes A. 1.4

		•	For State Registrar	State of Maryland		artment of H rtificate of I			Reg. No.	07358
P	Physicia	an	1. Decedent's Name (First, Middle, Las	- h				2. Date of Dea	Day, Year	3. Time of Death 5AM M
	/Medic	cal .	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	rebrua	4c. County of Death	
A	LAGIIIII		Hangland or H	YITTSUICE	- 4 6 - 46 - 4- 1	HYAJI If Under 1 Year	SUILL C	8. Date of Birt	PRINCE G	place (State or Foreign
	Funeral Director		5. Social Security Number 6. S 577-44-1522	7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	(Month, Day	y, Year) Cou. 1933	place (State or Foreign intry) DC
and	» _d		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
Mary	a-f sho	tor	DC				Washir			1 X Yes 2 No
/ith the	or 28. be not	Dire	10e. Street and Number			10f. Zip Code	10020		10g. Citizen of What Cou	-
leath v	ns 23a must	Funeral Director	1527 38th Street 11. Marital Status	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	20020 lispanic Origin? (Sp	ecify Yes or No		ican Indian,
after	f Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 □Yes 2 X No If Yes, Give		1 ☐ Yes 2 ☒ No		nicali, etc.)	Specify: Afr	ican
-UCS	atural"	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece	edent's Usual Occup	eation	ving	16b. Kind of Business/I	rican ndustry
7 Initi	ne. nan "n Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retired	d)		C-16 T	1 J
illed w	Hygier ther the	Cor	17. Father's Name (First, Middle, Last,	3		Real Esta			, Maiden Surname)	mployed
aryland should be file	i and Mental Is marked o raumatic eve	To Be	Bert S.	Hall Sr.					Clark	
0	h and I	ľ	19a. Informant's Name/Relationship (1	ing Address <i>(Street</i> 7 38th St			er, City or Town, State, Z $ an_{f s}$ DC 20	(ip Code) 020
ר, בּ	Health tem 27 other tra		Patricia Q. Hall 20a. Method of Disposition	20b. F		osition (Name of ematory or other pla		Date	20c. Location - City or	
Saltimor			1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Hemoval from State	Lin	coln	reb.			, Maryland
Balt	Department Important: If any injury or once.		21. Six ature of Funeral Service Licer	the cont	111-4	001 Benn:	ing Road	NE Was	uneral Home hington, DC	
			23a. Part1 Enter the disease, or com shock, of heart failure. List only						rrest,	Approximate Interval Between Onset and Death
	hysicían /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq		e HER	at fin	lord		
	xaminer	ı	Conventially list conditions	b.	401100 017.					
70	sit =	iner	Sequentially list conditions, if any, leading to immediate causes. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):					
U,	in and rial-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
08/60 Easte be	physician and the burial-transit	edical		_d						
Box 6	attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnature 1 Live birth 2 Feta	ancy	□Ectopic pregnanc			23d. Date of de	•
. 7	by the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of c		Other (specify)			Month	Day Year
ر. 5. ٿا	igned by be detach		Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contribute to	the cause of death?
ecords,	been sign	ed by	Coroner Pro	s DISMISK, (incom	1.5 Mire	13/5 4/15	/ 10	Yes 2 No 3 P	robably 4 Hiknown
Kecc	has be	Completed	GRAFT					24a. Was auto perf	opsy prior to death?	utopsy findings available completion of cause of
			25. Was case referred to medical				26. Place of Dea		2 No 1 Yes	2 No
	this cer al direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐		BIIL SU DOA		τ.	sidence 6 Other (Spe	ecify)
	After th		27. Manner of Death 1 Matural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ıryat ork?]Yes 2∐No	28d. Describe	how injury occurred	
Division or	after death Director: in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not to 4 Homicide determined	e 280 Place of injury - At h	ome, farm, s fy)	street, factory, office		28f. Location City or To	(Street and Number or Rown, State)	ural Route Number,
- Idiasan	4 hours of Funeral tely filled	Medical Co	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, dea	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and manner a e, date and place, and du	s stated. e to the cause(s)
į.	within 2 To the complex	Me	29b. Signature and title of certifier	1 2.			se number		29d. Date signed (Mon	
	5		Lite Mi	le Me		DC	026027	4	2/16	1-091
	14		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type VLSS-	e, Print)	us/more	en A	1000	>
	St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ing. Fraure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2011 Physician/ Month 2 Sinj Medical 4c. County of Death 4a. Facility Name (if not institution Town, or Location of Death give street and number) Examiner 9/01900 James If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Numbe 7. Age (In yrs. Country) MD. **Funeral** Months Days Nov. 30, 1917 1 □ M 2🛣 F Hours Min. Director 93 220-01-6861 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Grantsville 1 Kyes 2 No Garrett 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21536 Starner Hill Apartment #103 death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married à 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 ₩ Widowed 4 Divorced "natural" Completed other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. It is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Hospital 12 Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Amy Mildred Coleman Murray Arthur Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 2327 Herrington Manor Rd. Oakland, MD. 21550 Heather Hanline (granddaughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State any injury or Oakland, MD. Pleasant Valley Cem. 2/18/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility D. A. Burdock Funeral Home, P.A. 1 N. 2nd. St. Oakland, MD. 21550 21. Signature of Funeral Service Licenses 21 N. 2nd. St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 4 hours disease or condition Medical resulting in death) Due to (as a consequence of) **Examiner** 1 day Pneumonia Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months Month Year Day 1 Yes 2 9 Unknown To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death.

To the Funeral Director: After this certificare has been signed by the completed filled in by the funeral director, page 2 should be detached P.O. | 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown of Vital Records, 1 \square Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending injury Division М 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a 2011 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 N.4th, Street Oakland, MD.21550 Robert Coughlin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 7 2011 Registrar

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25 Day **Physician** 2011 4:03 a M Dorothy Elaine Hanlin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Garrett Dennett Road Manor Nursing Home 0akland If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 03 24 Birthplace (State or Foreign Country)
 WV 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🔀 F 1925 85 Director 236-82-1758 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Madical Examiner must be notified at 1 ☐Yes 2 No Director WV Mt. Storm Grant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21539 HC 76 Box 540 Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: Completed by White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be i 2 should be fi h and Mental h Amelia Entler Walter Foley ဥ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heath ar, Important: If item 27 is n any Injury or other traum once. HC 76 Box 540, Mt Storm, WV 26739 Gloria Kessel-daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State 2/28/2011 Mt. Storm Cemetery Mt. Storm, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of meral Service Licens 22. Name and Address of Facility David A. Burdock Funeral Home. 21 N. 2nd St. Oakland, MD 21550 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician week /Medical Du to (or as a consequence of): Examiner numo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a donsequence of): requires that the death certificate be executed burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

32. Registrar's Signature

- Ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

eru

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Thomas Henry Hughes 3945M February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Salis burg Rehabilitation & Nursina Ctr. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Oct. 23 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 1**X** M 2 □ F Months Hours 217-42-5873 67 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Hurlock Dorchester MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 United States Funeral 4515 Elwood Camp Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Poultry Chicken Processor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula R. Quailes ၉ Daniel J. Hughes, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4515 Elwood Camp Rd., Hurlock, MD 21643 Glenda Palmer Hughes/Wife 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XBurial 2 Cremation 3 Removal from State Hurlock, Maryland 2/26/11 Petersburg Cem. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 CF5P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ 0 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Duz to for earls consequence of ir any, leading to immedicause. Enter Underlying Exami been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 autopsy performed 1 🗀 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Ofieck only one) examiner? 2 4 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Anatural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William 200 Civic MI 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 7/2009

Registrar

FEB 23

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 February 11:15 P™ Rena Elizabeth Hall Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Tranquillity at Fredericktowne 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** Mary Land Hours 1 □ M 2 🛛 F 1918 217-10-0927 92 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State Director Frederick Frederick Maryland 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 323 Braddock Avenue 21701 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces ģ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: If Yes, Give White "natural". 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a, Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Service Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Frances Ray Davis Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Vera Hawkins, Daughter 8734 Yellow Springs Rd, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt Olivet Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Feb 28, 2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Kreenev & Bastord P.A. Funeral Home 106 East Church St. Frederick, Maryland M00706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition MAG Medical resulting in death) Due to o as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Du to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached for 1 ☐ Yes 2 15 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been si should I 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? this certificate has ral director, page 2 performed 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA e Hospina.

n 24 hours after death.

ne Funeral Director: After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

the

Muhammad Khalid Waseem, M.D., 1126 Opal Court, Hagerstown, Maryland 21740 31. Date filed (Month, Day, Year, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check

only one)

MAR 0.8 2011

arka

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

2011

2

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:00 PM Martin Luther Hare 2011 02 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Allegheny** Cumber land Allegheny County Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days Hours 01/25/1936 Cumberland, MD 1**XX**M 2 □ F Director 217-30-1993 74 Usual Residence of Decedent f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Maryland Examiner must be notified at Director 1 X Yes 2 No 28a-f Cumber land MD Allegheny 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a Funeral with USA 21502 306 Auburn Avenue "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXNo 3 Widowed 4XXDivorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing Company 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ James Edward Hare Opal Virginia Wolford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other fram Opal R. Robinson (Daughter) 833 Shriver Avenue, Cumberland, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State WVU Memorial Vault 02/18/2011 Morgantown, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WVU Human Gift Registry Signature of Funeral Service Licenses PO Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner canal Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exam that the death certificate be executed ZUNE and -tran Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Box 68760 the SS. IF FEMALE: asn yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy j in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death 2 No the 9 Unknown P.O. signed by to detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical 26. Place of Death ___ ck only one) Be examiner? Other: 2 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of the Funeral director after this ompleted filled in by the funeral director. 27, Mann 28b. Time of eath 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Investigation Accident 3 Suicide
4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

only one) 29b. Signature and title of certifier

31 Daned Month Day, Year)
VAR 0 8 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Da February 23, Year 011 1335^M Lola Isabel Irvin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Maugansville 14015 Village Mill Drive Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛶 I Jamuary 13,1932 Maryland Director 217-32-7397 79 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director r 28a-f 1 XYes 2 No Maryland Washington Maugansville 10e. Street and Number 23a or 10g. Citizen of What Country? Completed by Funeral 14015 Village Mill Drive 21767 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Black, White, etc. ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours afti and Mental Hygiene. 'is marked other than "natural", White 3 XWidowed 4 Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Aide Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Jesse Miles Sr. Lola Hawbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Clyde L. Irvin Jr Son 14015 Village Mill Drive, Maugansville, Md. 21767 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery 02-26-11 Clear Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License A Name and Address Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complication, y at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner arene ower Sequentially list conditions if any, leading to immediate cause. Enter Underlying Aeriphera the attending physician and hed for use as the burial-transit Vasa death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy In the past 12 months? 5 Other (specify) Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an cate has b page 2 sl autopsy Hospital or Attending Physician: The Is Abours after death. Funeral Director: After this certificate h performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1 ☐ Yes ≥ No ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? 2 🗌 No Investigation 2 Accident 3 Suicide 4 Homicide To the ... within 24 hour... To the Funeral Direc... ~upleted filled in by thr 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Kutzera,

31. Date filed (Month, Day, Year)

USH-3

Box 68760

P.O. |

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 23:22 P^{M} Howard Vincent Jones Sr. February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 | F (Month, Day, Months Days Hours Min. Director 83 579-34-7437 Sept. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-fs other traumatic event, the Medical Examiner must be notified 1 X Yes 2 No DC Washington 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 20020 2700 Jasper Street SE # 212 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced Year or Dates American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Rural Electrification Clerk Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Jones Ruth Magruder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon M. Jones-Taylor/Daughter 2244 Anvil Lane Temple Hills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Heritage
Memorial Cemetery 20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or 2011 4 Donation 5 Other (Specify) Waldorf, Maryland Signature of Funeral Servic License 22. Name and Address of Facility Stewart Funeral Home, Inc. ↑4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed ophagea that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phone IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year g 🗔 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral E Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check only one 29b. Signature certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				For State	State o	f Marylar					and M	1ental Hy	giene	ອີດ	1	07266			
				Registrar 1. Decedent's Name (First, Midd	lle l ast)		Cei	tificate	e of L	eath			Reg. N	6- 0		07366			
		ysicia Medio		Arnold Kandel		<u>.</u> .						2. Date of De Month	Day 27 201:			3. Time of Death 05:00 A M			
) E	kamin	er	4a. Facility Name (if not institution		ber)		4b. City,	Town, or	Location of	of Death	40	4c. County of Death						
	·			Suburban Hospital 5. Social Security Number		7 4 7		Bethe			0411		_	ontgom					
		neral ector		578-26-4859	6. Sex 1 X M 2 D F	7. Age (In yrs. 83		If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Apr •	th 2 / 1	9. Birthplace (State or Foreign Country) Washington, DC					
	pc work	ta	r	Usual Residence of Decedent 10a. State 10b. Count	v	10c Cit	ty, Town or Lo	cation							1.	0d. Inside City Limits			
	Marylai 8a-fs	tified	Funeral Director	MD Monte	Jomery		kville						1 🗆 Yes 2 🙀 No						
	a or	pe no	٦	10e. Street and Number				10f. Zip	Code				10g. C	itizen of W	f What Country?				
	h with	nust	ner	11420 Strand Dr.	#407			2	0852				U.S	.A.					
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho	event, the Medical Examiner must be notified at	۵	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	Armed For	2 No	l I	Vas Decede Yes, speci	fy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White W Specify:			an Indian, atc. ite			
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Maryland	12 should be file lith and Mental H	ic ev	ျှ	Max Kandel	,					Evelyn		(First, Middle,	waiden	Surname)					
ary	hould and M	umat		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address	(Street a.			Route Numbe	r. Citv oi	r Town. Sta	ate. Zio C	ode)			
	of Health of Item 27 i	er tra		Rhoda Kandel - Wi	.fe							ille, MD			, ב.թ •	- 40,			
Baltimore,	Page 1 arment of Hearmant; If iter	or oth		20a. Method of Disposition 1 ፟፟፟∭ Burial 2 ☐ Cremation	3 Removal from 9	20b. F	Place of Dispos	sition (Name	e of			ate		ocation - (City or To	wn, State			
ţi	t. Pag tmen	jury		4 Donation 5 Other	Specify)		ng David			· .	/30/2	011	Fal:	ls Chu	rch,	VA 22042			
Ba	permit. Departr Imports	any injury or once,		21. Signature of Funeral Service	Licensee Lacetelli	CCO:	-1-1	Name and			Nati	onal Fun	eral	Home					
				23a. Part 1. Enter the disease o shock, or heart failure. List	r complications that ca only one cause on eac	aused the deat	h. Do not ente	r the mode	of dying	, such as c	ardiac or	respiratory arr	est,			Approximate Interval Between			
	hiysic			Immediate Cause (Final disease or condition	a_Pseud	omonas Pi	neumonia									Onset and Death			
بمبييه	Med Exam			resulting in death)		r as a consequ	,												
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387	rtifica ing pł	as #		F FEMALE;	T						_								
. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. 44 hours after death. 46 Hours Different After this certificate has been signed by the attending physician and after the final in the form.	ched for use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 ☐ Feta ant at time of d	I death 3 🗌	Ectopic pro Other (spe						23d. Date Mont		y Day Year			
P.O.	that t	e deta	y P	Part II. Other significant condition					_			23e. Did to	bacco u	use contrib	ute to the	cause of death?			
ds,	v requires been sig	q pind	9	Chronic Obstructiv	ve Pulmary Di	sease, C	hronic K	idney	Dise	ase,		1 🗆 ነ	es 2	□ No 3	☐ Proba	abiy 4🏝 Unknown			
ecor	sician: The law re	DS00	Completed by	Congestive Heart	Failure							24a. Was a autop perfor	sy	pri	ere autops or to com ath?	sy findings available pletion of cause of			
E .	in; Th	or, pa		25. Was case referred to medical					06 01-		(0)1	1 🗆 Yes			Yes 2	! □ No			
Vita	ysicia s cert	director	o Re	examiner? 1 ☐ Yes 2 💢 No	Hospital:	patient 2 🗆 I	ER/Outpatient	3 🗆 DOA	Loui	e of Death		ne 5 🗆 Resid			(0)				
Division of Vital Records,	ding Phys th. After this			27. Manner of Death 1 🔼 Natural 5 🗌 Pendir	28a. Date of (Month)		28b. Time of injury	280	. Injury a work?	at	28	Bd. Describe ho			//				
visio	r Attend ter deatl rector:		Certificate:	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be 28e. Place o	f Injury - At hor	me, farm, stree	M et, factory, o		es 2 N	_	8f. Location (St			or Rural F	Poute Number,			
<u>ה</u>	Spital c hours af ineral D	and med in		29a. Certifier 1 X Certifying							1	City or Town							
	vithin 24 h	Kand	Med	only one) Sertifying	Physician: To the best examiner: On the basis Nurse Practioner: To	of examination	and/or investig	ation, in my ath occurre	opinion d at the t	, death occi	urred at the	ne time, date an	nd place	and due to	the caus	e(s) and manner stated			
	੭⋾₽ ∤⊀┃	d day	2	29b. Signature and title of certifier	uk			29c. L	icense r 0068			2		e signed (/ ./27/2(ly, Year)			
	0	A	3	30. Name and address of person v		,	, , , , ,	,	. 4.1-	a_ 100	2005								
		State	3	J. David Guevara- 1. Date filed (Month, Day, Year)	3. Rec	01d Geor			ernes	ua, MD	2081	4	-						
		jistrai		FEB 172	1011 Den	w B	are American												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17357 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. Dal 8, 2011 Physician/ Manprit Singh Kohli 16:45 P M Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Dea Silver Spring Town, or Location of Death Examiner County of Death Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Feb. 18, 1947 7. Age (In vrs. last birthdav) **Funeral** Sex 9. Birthplace (State or Foreign Days Hours Country)
India Director 64 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland "natural", or items 23a or 28a-f sho 10d. Inside City Limits Director 1 Ves 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11714 Georgia Avenue 20902 India 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Completed by 2 XNo Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates Sikh er than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within .
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic event, the Money. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Pizza Bolis Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ S. Jodh Singh Kohli Raj Kaur Kohli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malik Akhtar (Friend) 14837 Fireside Dr. Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremenation 2/27/2011 New Delhi, India Signature of Pureral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home reev 9013 Annapolis Rd. Lanham, MD 20706 Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final Physician/ Acute Nonstemi disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Acute Multiple CVA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by alcohol abuse, Diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed Yes 2 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 1/ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) D068681

Registrar

1500 Forest Glen Rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charu Maheshwary

31. Date filed (Month, Day, Year)
FER 2 3 2011

		Pleas	se Type or Pri						_		_	ible.		
		For State	State of M	arylan		epartm Certifica			d Mental H	ygien	e		07060	
		Registrar 1. Decedent's Name (First, Middle,	Last)			Sertifica	ate or t	Jeain	2. Date of I	Reg. N	lo.		3. Time of Death	
Physicia Medic		Mar	ion Kennely						Month Februa	ary 2	20, 20	Year 11 1	5:05 A M	
Examin		4a. Facility Name (if not institution, g				4b. C		r Location of D	eath		c. County			
Funeral		1110 Cedar He: 5. Social Security Number	6. Sex 7. Ag	e (In yrs. la	ast birth		der 1 Year		Hrs. 8. Date of E			9. Birth	George's	
Director		579-28-0011	1 X M 2 □ F	86	Y	rs. Monti	hs Days	Hours N	Min. (Month, i	Day, Year,	24	Sou	th Carolina	
and show 1 at	lor	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town	or Location		***					10d. Inside City Limits	
Maryl 28a-f otifie	irec	Maryland Prince	George's					itol He	ights			1 🕱 Yes 2 □ No		
vith the 23a or st be r	Funeral Director	10e. Street and Number	hta Drivo	10f.	Zip Code	0743		_	Citizen of W U nite					
leath v	Fune	1110 Cedar Heig	12. Was Decedent E Armed Forces?	ever in U.S	3.	13. Was De			' (Specify Yes or Nuerto Rican, etc.)		14. Race	- Ameri	can Indian,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Wildowed 4 Divorced	rried 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1 ☐ Yes 2 ☒ No Specify:								Specify:	k, White, B1	, etc. .ack	
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nd 2 sh saith ar n 27 is er trau		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Adrina Battles - Daughter 706 Castlewood Place Upper Marlboro, I												
ge 1 ar it of He If iter or oth		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	0	emeterv	Disposition (/ crematory c	or other place	ce)	Date /0./2011	20c.	Location -	City or T	own, State	
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permit Depar Impol any ir		1. Hand	Towar	1-1	AR				tewart Fo				20019	
		23a. Part 1. Enter the disease, or conshock, or heart failure. List only	omplications that caused y one cause on each line	the death	h. Do no	t enter the m	ode of dyin	g, such as card	diac or respiratory	arrest,			Approximate Interval Between	
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Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the but	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									23d. Date of delivery Month Day Year			
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requires that the de been signed by the should be detached	<u>م</u>	Part II. Other significant conditions	s contributing to death bi	ut not resi	ulting in	the underlyin	ng cause giv	ven in Part I.					he cause of death?	
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or Atte	Certificate:	3 Suicide 6 Could no 4 Homicide determine		ry - At hoi . (Specify)	me, farm	, street, fact	ory, office			(Street al		or Rura	l Route Number,	
To the Hospital or Attending Pothin 24 hours after death. To the Funeral Director. After the Completed filled in by the funeral	ledical	29a. Certifier 1 XCertifying P	hysician: To the best of r	my knowle	edge, de	ath occured	at the time	, date and plac	e, and due to the o	cause(s) a	and manner	as state	ed.	
the Hothin 24 the Fu	≥	(Check 2 ☐ Medical Exa only one) 3 ☐ Certifying N 29b. Signature and title of certifier	uminer: On the basis of ex urse Practioner: To the I	amination best of my	knowled	ige, death oc	curred at the	e time, date and	ed at the time, date I place, and due to	the cause	(s) and mar	ner as s	tated.	
		29b. Signature and titles certifier	Panvo				9c. License	275°	フフ	29d. Da	ate signed	(Month,	Day, Year)	
10		30. Name and address of person wh									101	///		
State		Ophnell Cumberba 31. Date filed (Month, Day, Year)				tral A	venue	Lando	over, Man	ylar	nd 20	0785		
Registra	-	FEB 2 3 2011 A	32. Regigira	Ma	Med									

DHMH 17 Rev 7/2009

Amend #30 per DVR g913 3/7/11 TT. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month CARL LAWRENCE KELLEY February 14 2011 10:37 p.^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Moran Manor Nursing Home Westernport Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 344-30-9922 73 Creal Springs, Director 28,1937 May Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director WV Mineral Burlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1, Box 147-A Funeral 26710 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Unknown 1 Never Married 2 Married , or altimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify Specify: White 3 Widowed 4 Divorced 'natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Engineer Aircraft Manufacturing Ith and Mental Hygie 27 is marked other the traumatic event, Ith 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Kelley မှ Hazel Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other tronce. Margaret Ann Kelley/Wife Rt. 1, Box 147-A Burlington, WV 26710 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 23 4 ☐ Donation 5 ☐ Other (Specify) Burlington Cemetery 2011 Burlington, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Smith Funeral Home Rt. 2, Box 1-A Burlington, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastatic Lung Cancer year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed nding physician and ise as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy log. in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the at d be detached for 5 Other (specify) o 9 I Inknown 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>۾</u> Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Director: After this 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after To the Hospital within 24 hours a To the Funeral filled Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21266 2/15/2011 and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Afram, MD 2440 M Street, NW Suite 411 Washington DC 20037 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parker Registrar MAR 0 9 2011

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 16 9:30a M Henry Libber 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 1 X M 2 □ F (Month, Day, Year) Maryland 013-07-2795 Director 98 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Rockville 1 Tes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20852 6111 Montrose Road, Apt. #303 12. Was Decedent Ever in U.S.
Armed Forces? Coast
1 2 Yes 2 No Guard
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Specify: White Completed WWII Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Medical Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Hershel Libber Celia Rauman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2507 Willow Glen Drive, Baltimore, Maryland 21209 Jonathan Libber - Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 🖾 Removal from State 4 □ Donation 5 □ Other (Specify) : 02/18/2011 Melrose, Massachusetts Vilkomir Cemeteru re of Funeral Service Lice 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
6 hows Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) g physician a s the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown 0 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 081 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Tes 2 X No 3 Probably 4 Unknown (G) 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 🔏 No prior to completion of cause of death? -16-11 2 🗆 No 1 Yes 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Other: 1 Tyes 2 X No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending Division To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be HENRY 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) BBER D0041311 February 16, 2011

State Registrar DHMH 17 Rev 7/2009 6410 Rockledge Drive, #200, Bethesda, Maryland 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Yuri Anthony Deychak.

18

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Haines Le Hew, Jr. Feb 16, 2011 12:05 P ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George Hospital Cheverly Social Security Numbe . Age (In yrs. **7**8 If Under last birthday 8. Date of Birth 9. Birthplace (State or Foreign Year **Funeral** 579 48 2747 Days Hours 1 □**X**M 2 □ F **Director** 1932 Washington DC Usual Residence of Decedent or 28a-f shov with the Maryland be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George Capitol Heights, 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must b Funeral 624 Capital Heights Blvd 20743 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 10 Black, White, etc \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 1952-1956 Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electrican Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe John H. Le Hew , Sr. Verda Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Kathleen Le Hew (wife) 624 Capitol Heights Blvd, Capital Heights, MD 20743 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1: Department of I injury Lee Funeral Home Crematory Feb 23 2011 Clinton 4 Donation 5 Other (Specify) Maryland 21. Signeture of Funeral Terror Licens 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Restrictive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Asbostosis History Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an certificate has autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🗶 No 은 1 Tyes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 2011 062165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Drive, Cheverly, MD 20785 Teshame Z. Tegene, M.D.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

FEB 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Τ. 2011 James Lloyd ebruar) Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b, City, Town, or Location of Death 4c. County of Death <u>Doctors Community Hospital</u> Prince <u>Lanham</u> Georges 5. Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1**X** M 2 □ F n 25,1954 Months Hours Min. Month D March Director 238-96-0233 56 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d, Inside City Limits MD PG 1 🔀 Yes 2 🗌 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6407 West Vein Road 20720 United States 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or Completed by 1 Never Married 2 XMarried Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: Black 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Year or Dates. item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I 12 Electrician Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Arnold Llovd Evada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6407 West Bowie, MD 20b. Place of Disposition (Name of Vein Road Carnette Lloyd/wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Md Veterans Cemetery 2/25/11 Cheltenham, Md. are of Funeral Service Licensee 21. Signal 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Multiple set and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown 2 \square No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3

Registrar DHMH 17 Rev 7/2009

State

ZWally

Jay 31. Date filed (Month, Day, Year)

FEB 2 3 2011

person who completed cause of death (Item 23a) (Type, Print)
ZWALLY 8118 Good LUCK Road LANHAM, Haryland. Z0706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 13, 2011 4:10 РМ Danzel Wanda Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Fox Chase Rehabilitation/Nursing Ctr 8. Date of Birth

(Month, Day, Year)

Dec. 26, 1910 9. Birthplace (State or Foreign Country) DC If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 M 2 🔀 F Hours Director 100 212-24-9744 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20910 2015 East West Highway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🛂 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene
Important: If item 27 is marked other the
any injury or other traumatic event. Administrative Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Johnson Daniel Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) # 21 Washington, DC 20002 1268 Raum Street NE Vassie Anderson – Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 23 2<u>011</u> Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Lice Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Hypertension 10 vears Medical resulting in death) Due to (or as a consequence of) Examiner Hyperlipidemia 10 years Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami ng physician and as the burial-transit that the death certificate be executed Alzheimers Disease <u>5 years</u> that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown detached 9 Unknown ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 No 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law performed? Yes 2 X No 2 🗌 No 1 Yes Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural 5 Pending work' nours after death.

neral Director: Affilled in by the fur 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Wednesd Examiner: On the basis of occurred at the time, date and place, and due to the cause(s) and manner as stated

P.O. Records, of Vital Hospital or Attending Division 24 hours a To the Hosp within 24 hou To the Funer completed file

Box 68760

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) Registrar

only one)

29b. Signature aportitle of certific

C.R.N.P. 15245 Shady Grove Rd. Suite 130 Rockville, Md. Babette Pennay, 32. Registrar's Signature

30. Name and address of persop who completed cause of death (Item 23a) (Type, Print)

R096053MD

29d. Date signed (Month, Day, Year, February 21, 2011

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 15, 2011 8:20 P Medical Lawrence Edward Leake 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Accokeek 15707 Henrietta Drive If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 1, 1945 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ፟ M 2 ☐ F Months Days Director 65 Pennsylvania 197**-**38-4228 A119. Usual Residence of Decedent 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No <u>Maryland</u> Prince George's Accokeek ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a United States 15707 Henrietta Drive 20607 within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 feath and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government 12th Space Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John A. Leake Mildred Cash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15707 Henrietta Drive Accokeek, Maryland 20607 Ann C Leake - Wife or other 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20b. Place of Disposition (Name of 20c. Location - City or Town, State ■Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 Benning Road NE Washigton, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock; or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metastastic Colon Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the attending physician and hed for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 1 Yes 2 No To the Hospital or Attending Physician: Twithin 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No 1 Yes ျာ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? ■ Natural 5 Pending injury Accident
Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and rinvestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number MD19730 February 22, 2011

Box 68760

P.O.

Division of Vital Records,

State Registrar

106 Irving Street NW 32. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Michael D. Cannaday,

1. Date filed (Month, Day, Year)

Suite 305

Washington, DC

20010

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

ro the Funeral

State

Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

and manner stated.

Dr. Jesus Tan, 4 Broadway, Frostburg, Maryland

FEB 1 8 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

21244

29d. Date signed (Month, Day, Year) 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
 Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DONNA DAWSON LEWIS 11:33 P M February Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Yea 82 188-22-8336 **Director** 1929 4 Pennsylvania Jan. Usual Residence of Decedent 28a-f show 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Sykesville Maryland Carroll 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral M117 7200 3rd Avenue United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. :em 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u> Iames Hamilton Dawson</u> Ursula Bundy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1745 Castle Rock Road, Frederick, MD 21701 Laurie Lewis (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2/19/2011 Smithsburg, Maryland 21. Signature of Funeral Service Licensee Keeney & Basiord P.A. Funeral Home MO1612 106 E. Church Street, Frederick, Maryland 21701 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ espirator disease or condition Medical resulting in death) Examiner Sequentially list conditions, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Yes 2 No Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ည 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural work? 1 ☐ Yes 2 ☐ No. 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 🇲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 — Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier arikova 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 00a 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Registrar

DHMH 17 Rev 1/200

State

30. Name and address of person

Tom

32 Registrar's Signature

610 Butchmans Lane, Easton, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month . 18, 2011 Lillian Mae Leeser 2:06P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Federalsburg 3534 Houston Branch Road 8. Date of Birth (Month, Day, Apr. 8, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months 1923 Days Hours 1 □ M 2 💢 F MD Director 218-16-830 87 Apr. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a fledical Exp. it are resulting at once. 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location Federalsburg 1 □Yes 2X No Caroline Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 United States 3534 Houston Branch Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ White Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Payroll Secretary Clerical G.E.D. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Mary Clevenger James Edward Mitchell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5962 Cokesbury Rd., Seaford, DE 19973 Elizabeth Paul/Daughter Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) t Burial 2 ☐ Cremation 3 ☐ Removal from State 02/20/11 Smithville, MD Bloomery Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee Lelose CFSP 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MACATORTONI weeks /Medical Due to (or as a consequence of): Examiner Sici Sequentially list conditions, if any localing to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 □ Yes 2 □ No certificate ha 1 ☐Yes 2 ☐ No After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number HO047523

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

D. O. 3304 thyman

32. Registrar's Signature

Druc Federalshur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. APPIOTT

31. Date filed (Month, Day, Year)

AS Y

Timothy	Wayne	Landon	
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Fimothy Wayne Lai	1-	For State	ate of Maryla		artment of rtificate of		Mental Hy		201 g. No.	07380		
Physician/		gistrar Decedent's Name (First, Midd	e,Last)					2. Date of Death	1	3. Time of Death		
Medical Examiner	_	TIMOTH	February 2	onth Day Year 0730 hr								
	42	 Facility Name (if not institution 216 Ullman Road 	n, give street and nu	imber)	['	b. City, Town, or L Pasadena	ocation of Death	Anne Arundel				
Funeral	5.	Social Security Number	6, Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birtl		9. Birthplace (State or		
Director		220-68-7504	1 M 2 F	53		Months Days	Hours Min.	09/05	/1057 F	oreign Count Maryland		
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the Maryland a or 28a-f sh tified at once	10	e, Street and Number				10f. Zip Code		10	g. Citizen of What	Country?		
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or deal			1 Yes	2 X No	1	Yes 2 X No	specify:		Specify:	White		
ural" ural"	` -	15. Decedent's Education (Spe	Lor Dates:		16a. Deceden	t's Usual Occupation	on (Give kind of w		16b. Kind of Busin			
5-0036 ed within 72 hour lygiene. other than "natu the Medical France Completed		Elementary/Secondary (0-12)	College (during m	ost of working life.	DO NOT use retir	ed)	Correc	tional		
036 ithin 7 ne. refer		12			Corre	ectiona	l Offic	er	Instit	ution		
5-0036 lled within 7 Hygiene. I other than the Medica		7. Father's Name (First, Middle	Last)			1	8.Mother's Name	(First, Middle, M	laiden Surname)			
17215-0036 Id be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 23a-f sho event, the Medical Laminer must be notified at once. Dee Completed by Funeral Director	با	Arthur T. La Pa. Informant's Name/Relations	ndon		10h Mailine	Addross (Stand	June	Tyler	ber, City or Town,	State 7in Code)		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene. Int: If item 27 is marked other than "matural", or items 23a or 28a-f she rether traumatic event, the Medical Traminer must be notified at once To ther traumatic event, the Medical Traminer. To Be Completed by Funeral Director				\						4D 21817		
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Baltimore, bernit. Pages 1 ar Department of Hee Important: If ite	1	Burial 2 X Cremation		rom State	crematory or oth		1 m a m v v a	3/5/20	11 Delm	nar DF		
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		MYION MACINE	2000 / FE - 1	A THE	3	06 W M						
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/Medical	l _{ir}	failure. List only one cause nmediate Cause (Final disease	NY	otic (he	eroin) I	ntoxicat	ion			Death		
Examiner		r condition resulting in death)		consequence	of):							
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1876 rtifica ing ph as the	23	b. Was decedent pregnant in the past 12 months?	ne 1 Live I	oirth	2 Fe	tal death 3	Ectopic pregna	ncy	Month	Day Year		
box 68760, the death certificate by the attending physiched for use as the but Physician/Mee	1	Yes 2 No 9 Un	7 7	nant at time of d	leath 5 Ot	her (Specify)						
Ply the de ched f	P	art II. Other significant condi	Ja Colley		resulting in the u	ınderlying cause g	iven in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?		
P.C s that s that e deta	3							1 Yes	2 No 3	Probably 4 🗸 Unknown		
Records, The law requires ficate has been signage 2 should be								24a. Was a		ere autopsy findings available		
COT law r has b				-	-			autoperfor	med? dea	or to completion of cause of ath? Yes 2 No		
H. The tifficate or, pag		5. Was case referred to medica	ai I			26.Place	of Death (Check		2 10 1	Yes 2 No		
Vital ysician ysician directo	۱	examiner?	Line-itely	Inpatient 2	ER/Outpatient	3 DOA	Other Nursin	g Home 5	Residence 6	Other: Scene		
of \officers of the representation of the re		7. Manner of Death	28a. Date	of Injury h, Day,Yaar)	28b. Time of	njury 28c. Injur	y at Work?	28d. Describe h	now injury occurred			
on sath.		1 Natural 5 Pen	dina	-26-11	fd 7:20)am │ ¹□ ʏ	′es 2 🗶 No	unknov	wn			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buil Medical Certification: To Be Completed by Physician/Med		9a. Certifier	hysician: To the be	of examination	dge, death occu	rred at the time, da tion, in my opinion	ite and place, and , death occurred a	due to the caus	e(s) and manner a	s stated. e to the cause(s)		
or Witi	2	9b. Signature and title of certifi	and manner : er	stated.		29c. Licens	e number		29d. Date signed	(Month, Day, Year)		
	l		M. 9			O.C.I	M.E.		February 27	, 2011		
_	3	0. Name and address of person							<u> </u>			
			puty Chief Medi	cal Examine	er 900 W.	Baltimore Stre	et, Baltimore	MD 21223				
State	~	1. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture							
Registra	_	MAK U 9 201	Senera	· 13. 1	A SOUND			7	0.0	OME		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 6:09 PM Physician Patricia -enhal 2011 rebruary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Pays Hours Min. 8. Date of Birth April 24, 1948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 1 □ M 2 😾 F 62 213-54-7277 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 ☐ No Jefferson Frederick Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21755 U.S.A. 4914 Shadywood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No White Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John E. Davidson Dorothy Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4914 Shadywood Drive, Jefferson, MD 21755 Clyde E. Lenhart, husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Monocacy Cemetery Feb. 24, 2011 Beallsville, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licens ਵਿੰਦਾਵਿਓ ^Aਬਾਰਿ ਓਬੰਡਿford PA Funeral Home 106 East Church St., Frederick, MD 21701 21. Signatu M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Depsis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Pulmonary

Due to (or as a conservence of) Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and d for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day page 2 should be detached for Pregnant at time of death 5 Other (specify) Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Tes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA 9 completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of . Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 24 hours after death.

Funeral Director: After 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19,2011 RES-000 February

State Registrar Satish

Date filed (Month, Day, Year)

MAR 0 8 2011

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Misca

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ĩo 11:00 p^M Diane Lynn Martin February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth
(Month, Day, Year)
April 26, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🔀 F Min. Country) Hours **Director** 160-72-7099 55 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1417 Elm Grove Circle 20905 USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗴 No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced "natural", Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Pharmacy Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Martin Pearl Mae Pledger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1417 Elm Grove Circle, Silver Spring, MD 20905 Menyone Lee Etta Bowers/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 19 20c. Location - City or Town, State any injury or 1 Burial 2 Cremation 3 Removal from State Alexandria, VA 2011 4 Donation 5 Other (Specify) Metropolitan Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring.MD 20961 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of impury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 x No ed by the a 9 Unknown P.O. been signed to should be deta Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Emphysema Records, Completed 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No Yes 2 K No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred : After ! 1 X Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the ful 1 🗌 Yes 2 🗎 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title certifie 29c. License number 29d. Date signed (Month, Day, Year) D32332 February 11, 2011

DHMH 17 Rev 7/2009

State Registrar Silver Spring, MD 20902

9801 Georgia Avenue,

32 Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Suresh Gupta,

31. Date filed (Month, Day, Year)

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and show lat	or	10a. State	a. State 10b. County 10c. City, Town of															10d. Inside	City Limits	
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nd 2 sho ealth ar n 27 is er trau		Donna Gail Moore/Daughter 8115 Flower Avenue, Takoma Park, MD 209																		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1																		
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical E	xamine	er: On the ba	sis of e	xamination	and/or i	investig	ation, in	my opinio	n, death	occurred a	nd due to the c t the time, d <i>a</i> te ce, and due to t	and place	ce, and due	to the c	ause(s) and	manner stated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MCCRAW HELEN 12 : 44 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death calvert county CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F **Director** 88 226-26-6143 Virginia Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Tes 2 No Calvert Dunkirk 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 2236 Harley Drive 20754 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Was Decedon. Armed Forces? 1 ☐ Yes 2 🙀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: If Yes, Give Year or Dates. Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) secretary insurance company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William . Fraser Beatrice Α. Gorland 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Kelley, friend 2233 Harley Drive, Dunkirk, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fairview Cemetery 02/28/2011 | Roanoke, VA Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Clostridium Detticile Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transil Cause (Disease or iinjury that initiated events resulting in death) Last Failure to thoire Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, failure, Anemia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred iniury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Aft
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) MD Thisunds 2/20/2011 D0064324

den 5 State

Box 68760

P.O.

Registrar

100 Hospital Rd, Prince Frederick, mD, 20678.

park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

Thibin Santha, 31. Date filed (Month, Day, Year)

Ame	end #5,p Dodrw	per	FD, 3/3/11	'Plea	se Type or	Print in	Black Ir	ndeli	ble Inl	k. Ens	ure A	II Copie	s Are	e Legil	ble.	
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	death items		11. Marital Status		12. Was Dece	dent Ever in U.	.S. 13. \	Vas Dec	edent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	-	14. Race	- Americ	an Indian,
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 3 Widowed 4		ed 1 Yes If Yes, Giv Year or Da	e ² X No			2 X No			, , , , , ,		Black, White, etc. Specify: white		
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Mary	2 should th and N 27 is ma trauma		19a. Informant's Name/ Arthur Dor			husban	1	_				ad, Ow				736
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ino	Page ment c ant: If ury or		1 Burial 2 C 4 Donation 5		3 □ Removal from Decify) E/ntomb	State	cemetery, cren o. Memo				02/2:	2/2011	Dun	kirk,	, MD	
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Box 68760	eath certifica attending p	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mon			Birth 2 Fet	aldeath 3		c pregnanc	у			-	23d. Date		
	hat the deat ed by the at detached fo	ysic	1 Yes 2 X No	0		4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown								Mont	n	Day Year
P.0	that the	by Pt	Part II. Other significan	nt condition	ns contributing to d	eath but not re	sulting in the u	ınderiyin	g cause giv	en in Part	I.	23e. Did	tobacco	use contrib	ute to th	ne cause of death?
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E R	sician: The law certificate has b lirector, page 2 s	Be Co	25. Was case referred to	o medical					26. Pla	ace of Dea	th (Check	1 Yes	2 X N	o 1 l	_ Yes	2 🗆 No
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Division of Vital Records, P.O.	To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:		Could n	ot be 28e. Place	of Injury - At h		eet, facto	ory, office				ion (Street and Number or Rural Route Number, r Town, State)			
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Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

ul or Attending Physician: The law requires that the death certificate be executed after death. Box 68760. P.0. Il Director: A

Division of Vital Records, within 24 hours a

To the Funeral C

completely filled Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date of Death Dav **Physician** Feb 17, Dorothy Trenary McCleaf 5:45 Am 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles County Nursing & Rehab LaPlata Charles Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** Days Min Months Hours Virginia Director 579 38 0874 Dec 16, 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examination must be rediffed at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 □ No Director Maryland Charles Bryans Road 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5851 Wosley Court 20616 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status 1 ∏Yes 2√ No If Yes, GiveA Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □No Specify: ģ Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Trenary Alice Wheeler 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carole Brown (Daughter) 5851 Wosley Court, Bryans Road, MD 20616 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery Feb 21, 2011 Rockville, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 23a. art 1. Enter the disease, or complications the shock, or heart failure. List only on ause of Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Tronic Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sela an inequation off: Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🔀 Nursing Home 1 ☐ Yes 2 No Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5625 tatina Hussein 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 3 201 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ros State Registrar Amend#20band20cperfuneralho**ner/ficate**01/1**2eat6**hrb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Francis Major Febth14, 2011 18:57P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 - F 216 34 8277 Months Days Hours Jan 21 1939 72 **Director** Mary Land Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County by Funeral Director 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Upper Marlboro 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14601 Mt. Calvert Road 20772 United States 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give Vietna 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify: Completed 3 Divorced 4 Divorced Vietnam Specify: White Year or Dates. nd Mental Hygiene. marked other than "natun matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Operations United Air Lines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental and and the Health and them 27 is man. 2 Willard A. Major Anna Briarly Hayward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Major (Wife) Department of Health Important: If item 27 any injury or other to 14601 Mt. Calvert Road, Upper Marlboro, MD 20772 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State unk. Cheltenham, MD March3,2011 4 ☐ Donation 5 ☐ Other (Specify) Maryland Verterans Cemetary 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Acute Atheroscienne cavaiovascular Diseas Onset and Death disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or se à consequence of; the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

t time of death 5 Other (specify) IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yes 2 No Year 1 Yes 2 L 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, C プンション c BACK Pans 1 Tes 2 No 3 Probably Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Hospital or Attending Physician; The performed of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **1**No 1 Inpatient 2 R/Outpatient 3 IDOA s after death.

I Director: After this ed in by the funeral d this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Division Accident
Suicide 1 Yes 2 No completed filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D 50689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANIL KMAHADAN, MD

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death Physician/ Month 200 M Maria Alice MONNINGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Day, Y (Month, Day, Y 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 💢 F Months Hours Min. Country)
Maryland **Director** 91 215-14**-**1775 A119. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🏋 Yes 2 □ No <u>Maryland</u> <u>Washington</u> Funkstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 218 E. Chestnut Street 21734 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education 8 0 Bus Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Shank Esther Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11301 Dogwood Drive, Apt. N Hagerstown, Md. 21740 Patricia A. Monninger -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beaver Creek Cemetery 2/26/2011 Hagerstown, Maryland 21. Signature of Funeral Service License Minnich Funeral Home 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final or bba Ph sician/ 10. INTACON disease or condition Medical resulting in death) Examiner Sactiontially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed after death. the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 🗌 No this certificate has been signed by the ral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 😕 No Hospital Other: |<u>|</u>| 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred I Director: After to in by the funeral Matural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 Fen ~ Sylvan NSH-2

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bernadette McCov February 20, 20 11 4:44 PM Medical 4a. Facility Name (if not institution, give street and number)
Prince George's Hospital **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince George's **Funeral** ocial Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 577-68-6030 1 □ M 2**X**□ F Months 5/6/1950 Director Washington, DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State MD 10b.County Prince George's **Funeral Director** 10c. City, Town or Location Landover 10d. Inside City Limits 1 😾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code log. Citizen of What Country? 1000 Brightseat Road 20785 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 TDivorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Kirkman & Ellis Elementary/Seconday (0-12) College (1-4 or 5+) Legal Secretary Law Firm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Abraham DeBose Julia Haynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron Fitz (son) 14606 Dervish Court Bowie, MD 20721 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2/26/2011 Brentwood, MD 21. Signature of Funeral Salice Librar ee 22. Name and Address of Facility Fort Lincoln Funeral Home nompso_ 3401 Bladensburg Brentwood, MD 20722 Road have 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Paysician Onset and Death MATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mmuno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of burial-trar resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy for Other (specify) Month Pregnant at time of death Day the detached g Unknown 9 Unknown To the Funeral Director; After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2X No 1 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director; After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗆 Yes 2 ី No ၉ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 🗌 Yes 2 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature d title of D63688 ompleted cause of death (Item 23a) (Type Print) Name and address of person 3001 MSDetal

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State Registrar 31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\overset{\text{Day}}{2}\underline{011}$ Feb. 18 12:45 AM Jose Luis Gomez Martinez Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventis Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign May 20,1953 1 X M 2 □ F Days Hours Min. Director 578-15-4752 57 Mexico Usual Residence of Decedent 28a-f shov items 23a or zoa-ı s... 10a, State 10h County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 ☐ No Maryland Prince Georges Lanham 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20737 5425 55th Place #202 Mexico 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò þ Black White etc. 1 Never Married 2 Married ☐ Yes 2 ☐ XNo Baltimore, Maryland 21215-0036 Specify: Mexican 1 X Yes 2 ☐ No If Yes, Give "natural" 3 Divorced Completed Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Construction Self Employed traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Romand Gomez Higinia Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sof Health 5425 55th Place #202 Riverdale, MD Jose Tinajero (son) 20a. Method of Disposition 20b. Place of Disposition (Name of . Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Tamaulipas, Mexico Cementerio Municipal io Municipal 2/26/2011 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature Funeral Service Licenses 9013 Annapolis Rd. Lanham, MD 20706 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. mmediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last consequence of) Physician/Medical Box 68760 as the signed by the attending I be detached for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 2 No Inpatient 2 - ER/Outpatient 3 - DOA Certificate: 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Hospital or Attending 28d. Describe how injury occurred injury work? Natural 5 Pending neral Director: Af 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)-Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Physician/ 201 3:09 Marion Easter Morgan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Queen Anne Queen Anne 13605 Railroad Avenue 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland April 20, Days 1 🖳 M 2 🗆 F Months Ye 1924 86 **Director** 218-16-6461 Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 XYes 2 No Maryland Queen Anne Queen Anne 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A 21657 13605 Railroad Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 X Yes 2 □ No 1942 Black, White, etc. φ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White "natural", 3 XWidowed 4 Divorced Year or Dates. to 1946 Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education during most of working (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) 11 H.S. Grad College (1-4 or 5+) Building Construction Grad. Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even Neighbors Marjorie Roland Wheeler Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1348 Market Street, Denton, Maryland D. Michelle Girven 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State March 3, 2011 | Hillsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 22. Name and Address of Facility Moore Funeral Home, P.A. Signature of Funeral Service Dicensee 12 South Second Street, Denton, Maryland 21629 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PROSTATE CANCER Pnysician/ YEARS disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 🗌 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signe 29d. Date signed (Month, Day, Year) 2/28 2011 3988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. David Smith,

21601

8221 Teal Drive, Easton, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Miss 6:40 Carol Jeanne Feh Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 3031 Basford Road Frederick Frederick Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral Months Days Hours 1 ☐ M 2 💢 F Vrs 45 Director 576-72-6593 106/1966 South Usual Residence of Deceder iral", or items 23a or 28a-f shov Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD <u>Frederick</u> Frederick 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 3031 Basford Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🂢 No Race - American Indian, Black, White, etc. 11, Marital Status þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔯 No Specify: Specify: white "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Frederick County Elementary/Seconday (0-12) College (1-4 or 5+) teacher Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other. ပ William Joseph Collins Patricia Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Miss / husband 3031 Basford Rd., Frederick. MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Mt. Olivet Cemetery 02/28/2011 Frederick, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home MUIZZZ 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ comes own disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 2 🗆 No 2 2 N 1 Tes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 🗷 No Other: 1 🔲 Yes 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours at er death.

To the Funeral Director A: 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide filled i∟ by the 1 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check з 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0/

Registrar

State

/ 46 B Thomas Johnson Dr.,

MD

Frederick.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kairouz

Sebastien S.

31. Date filed (Month, Day, Year

MAR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARY REBECCA WALBERT MEIKLE FEBRUARY 24 2011 1:28 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice of Queen Anne's Centreville Queen Anne's Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F 219-34-2132 Director 69 May 1, 1941 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Kent Worton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26096 Lambs Meadow Rd. within 72 hours after death 21678 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 □No Specify White ò Specify: 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Doctor's Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ George Alfred Walbert Mary Eileen Forrest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) J.R. Hanson Meikle, Jr. (son) 26006 Lambs Meadow Rd. Worton, MD. 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State I.U. Cemetery 2/28/11 4 Donation 5 ☐ Other (Specify) Worton, MD. 21. Signature of Fundal Service 22. Name and Address of Facility Calena Funeral Home of Stephen L. Sci 118 West Cross St. Galena, MD. 21635 M00510 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea/t failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adenocave in oma of Lung with Motasta monta /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infilmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a sonsequence of) Physician: The law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Day Month Year Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Squamous Coll Course 1-X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 2 🗆 No 1 ☐Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. 1 ☐Yes 2 ☐No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Hospital or Attending 124 hours after death.

le Funeral Director: A pletely filled in by the fu within 2 To the I

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical

completely

Neil Stoddard, M.D. 100 Brown St. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D00500

Chestertown, MD, 21620

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Curtis Miller 4:40 P.M Gordon February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 51 E. Water St. Smithsburg Washington If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea ulv 5 1 Months Days Hours 51 Michigan 220-78-2487 **Director** Ĩ959 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner miss he motified at . I Hygiene. I other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Smithsburg Washington Md. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A Funeral 21783 51 E. Water St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rosemary Sumerix Rosemary Gordon Curtis Miller မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Water St. Smithsburg, Md. 21783 Michelle M. Vidal (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dateunk 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Long Rapids Cemetery Long Rapids, MI. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. le like J.L. Davis Funeral HomeSmithsburg.Md.21783 M01414 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Squamous cell carcinoma orophari Physician/ omonths disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): vears Hupertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 1F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown cate has been signated by page 2 should by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 Z No Other: 4 Nursing Home 5 🕅 Residence 6 🗌 Other (Specify) 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2/25/2011 Yate m Smoth CRNP R128088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kate M. Smith CRNP

31. Date filed (Month, Day, Year)

MAR 0 8 2011

DHMH 17 Rev 7/2009

1126 Opal Court

32. Registrar's Signature

Hagerstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar <u>Amend#20bperfunera1home2/25</u> Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Feb 14. 201 William C. Noullet 2:20 Am M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Nursing Home Fort Washington Prince George's . Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 □ F **Funeral** Nov 3, 1919 Months Days Hours Min. Butler, Pa **Director** 91 171 12 5173 Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes XX No Camp Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4410 Henderson Road 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Year or Dates. Korean 1 ☐ Yes 2xxx No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 4 System Analyst marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William F. Noullet Laverne Clinger and 2 should the Health and Meter 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doreen D. Noullet (Wife) 4410 Henderson Road, Camp Springs, MD 20748 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 11, 20**1**1 Arlington National Cemetery 'Arlington, Virginia 21. Signature of Funeral Service Lice 1001555 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Adde Physician/ Canco disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate Cause (Disease or linjury burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be the as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Day Pregnant at time of death 5 Other (specify) Month Year the 1 ☐ Yes 2 ☐ Unknown þ s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe 2 K 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this (28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coursetin Road, Fort Wastington un 31. Date filed (Month, Day, Year). State Registrar

DHMH 17 Rev 7/2009

Box 68760

Ö

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene Registra MFND#25perMD, 2/18/11; brw, MCO Certificate of Death Reg. No. 2 Date of Death Physician/ Month FEB 2011 1931 Frank McGinn Porter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 217-28-8692 1 X M 2 □ F Months Days Min. DEC 19 81 Director Washington DC Ĩ929 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 3118 Gracefield Rd. T-14 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates. 1955 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72... th and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) National the Plant Pathologist 5+ Arbortum other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Than Oscar Porter McGinn Frankie Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Jean Marie Porter/Wife 3118 Gracefield Rd. #T-14, Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
ife Legacy
oundation ☐ Burial 2 ☐ Cremation 3 💢 Removal from State 4 X Donation 5 Other (Specify) 2/18/2011 Tucson, AZ . Signature of Funeral Services icensee 22 Name and Address of Facility Thibadeau Mortuary Service, p.a. 7 Park Ave., Gaithersburg, MD 20877 M00956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Multiple Sclerosis Sequentially list conditions, cause. Enter Underlying e burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 X No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\overline{\ove Other: ၉ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aff
d in by the fur Accident Suicide Investigation To the ...

Within 24 hours ...

To the Funeral Directu...

Tompleted filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D59521 ouler ermana February 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Loveen J. Puthumana,

FEB 17 20

31. Date filed (Month, Day, Year,

MD

3110 Gracefield Rd., Silver Spring,

MD

20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen PISNER February 18, 2011 4:20 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec. 17, Year 925 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Davs Virginia 85 Yrs. Director 578-24-1126 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Ħ 10c. City, Town or Location 10d. Inside City Limits Director r than "natural", or items 23a or 28a-f s the Medical Examiner must be notified Silver Spring Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20904 United States 13217 Sherwood Forest Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working 2 should be filed within 72. h h and Mental Hygiene. 7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hannah Sollod Samuel Horwitz permit. Page 1 and 2 st.
Department of Health an.
Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20895 2921 University Blvd., W., Kensington, MD Leigh Pisner, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) David Memorial Garden 02/18/2011 Falls Church, VA Kina 21. Signature of Funeral Service Licensee M01008 Torchansky Hebrew Funeral Home <u>254 Carroll St., NW, Washington, DC</u> 23a. Part 1. Enter y e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Myelo-monocytic leukemia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury Examine Due to jor as a consequence of law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 (No 9 Unknown 9 I Inknown P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, p. **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 **X**No Other: 1 Tes ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36797 Feb. 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Sheff, 10215 Fernwood Rd., #100, Bethesda, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

18

11-01571 Mark E. Plantz

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mark E. Plantz		State of Maryland / Depar 1-For State Certi	tment of <i>ificate of</i>		Mental H		2011	07399
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Mark Eugene Plantz				2. Date of Deat Month February 2	h Day Year	3. Time of Death 1240 hrs
		4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center		4b. City, Town, or Lo Glen Burnie			4c. County of Dea	el
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. las	t birthday) Yrs.	Months Days	If Under 24Hrs Hours Min		h(MM/DD/YYYY) 9. B 10, 1959 C	
Maryland r 28a-f show any ed at once.	Director		own or Locati en Bur			10	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No untry?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1605 Jennings Road 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced of Lever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1	21061 s Decedent of Hispa es, specify Cuban, M Yes 2 X No s 's Usual Occupation	Mexican, Puerto	Rican, etc.)	14. Race - Ame White, etc. Specify: Wh: 16b. Kind of Business	
-0036 d within 72 hourspiece. Tygene. ther than "na	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 3		ost of working life. D	O NOT use reti	red)	Shippi	,
MD 21215-0036 nd 2 should be filed within 7 nth and Mental Hygiene. m 27 is marked other than aumatic event, the Medica	To Be C	Milton Andrew Plantz 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing		Jean	Ann Wil:		e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		1 Rurial 2 To Cremation 3 Removal from State Cre	nce of Disposi matory or oth ropolit	tion (Name of cernet er place) tan Crema:	tory	Date March 1 2011	VA 23086 20c. Location - City o	a, VA
Balti Bernit. Depart Import Injury		21. Signature of Funeral Service Licensee 22. No 1503 23. Part I. Enter the disease, or Emplications that caused the death. Do	22. Na rat p00	ame and Address of ncis J. Co Universi	Facility ollins ty Blvd	Funeral	Home Inc.	ng, MD 20901
/Medical Examiner	ıminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Atherosclerot Due to (or as a consequence of): Due to (or as a consequence of):	ic Car	diovascul	ar Dise	ease		Between Onset and Death
executed an and al - transit	edical Examiner	events resulting in death) Last Due to (or as a consequence of): d. AMENDED 23a,27	per me	g913 3-1	8-11 vt			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transit	21	IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Feta	al death 3	Ectopic pregnar	ncy	23d. Date of deliver Month	y Day Year
ords, P.O. w requires that the sbeen signed by the should be detached.	2	Part II. Other significant conditions contributing to death but not resu	Iting in the un	derlying cause give	n in Part I.	-	acco use contribute to	
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the rafter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed					24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
Yital Physician r this cert	ě	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER		3 DOA Oth			esidence 6 Othe	r:
ision of Attending Pher death.	Certification:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year)		d. Describe how injury occurred				
Divisior Hospital or Attend 24 hours after death Funeral Director:		Suicide 6 Could not be determined (Specify) 29a. Certifier Control of Developer To the best of miles of miles of miles of the control of the				or Town, Sta	ite)	ural Route Number, City
To the Ho within 24 F To the Fu	edic	Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		n, in my opinion, de	ath occurred at	the time, date ar	nd place, and due to th	ne cause(s)
- Lear		29b. Signature and title of certifier Would The World Street Course of the Street Course of	2)	29c. License nu O.C.M.E		I	29d. Date signed (Mo February 26, 20°	
		Margarita Korell MD. Assistant Medical Examiner		Baltimore Stree	et, Baltimore	e, MD 21223		
Sta Regist	ite	31. Date filed (Menth, Day Year) 33 Registrar's Signature	park					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month RuATA 21, 20, Physician/ Virginia Palmer Glendora 5:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Meritus Medical Center Washington Hagerstown Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 7 Age (In vrs. last hirthday 8. Date of Birth Funera Days Min. (Month, Day, Year) 1 M 2 T F 94 217-32-6678 Director 1916 Marvland March Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 10114 Sharpsburg Pike 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Hygiene. other than "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Me lical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Deli Manager Grocery Store and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gertrude Anna Florence Gantz William Albert Evers Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 8428 Harris Avenue, Parkville, Maryland 21234 Wayne L. Palmer/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 02/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home 7606 Old National Pike, Boonsboro, Maryland 21713 23a. Part 1. Enter the disease, or complications that caushool, or heart failure. List only one cause on each d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami and -transit Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a d be detached f Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 📈 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has performed? Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical Division of Vital or Attending Physician: 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 2 0 NO 1 Yes ည 1 Denpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Il Director: Aff Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in t 24 hours a Hospital Medical 29a. Certifier 🖊 Ϲ ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 29b. Signature and title of certifier MOS Northern And Hagarston MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-5 583 MY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar

Box 68760

P.0.

Records,

Division of Vital

1450 Mercantile Lane Ste. 217

Largo, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FACC

MD,

David A Gooray,

31. Date filed (Month, Day, Year)

FEB 2 3 201

Box 68760, Division of Vital Records, P.O.

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and To the Hospital of within 24 hours at To the Funeral D

Certification: To Medical

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Qamar Zaman, 12500 Willowbrook RD, Suite 440, Cumberland, MD 21502 31. Date filed (Month, Day, Year)

FEB 2 5 2011

4 Homicide

29b. Signature and title of certifier

29a. Certifier (Check only one)

32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEB. 18 pay 201°1 **Physician** 7:20 A M Vickie Sue Plutschak /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline 100 Fooks Avenue Preston 8. Date of Birth (Month, Day, Ye March 19 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 T F 46 **,**1964 219-82-1891 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, its Medical Examinar must be notified at 1 XYes 2 □ No Preston Director Caroline MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 72 hours after death with United States 21655 100 Fooks Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, its Michigan. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Donovan James Burklew ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 100 Fooks Avenue, Preston, MD 21655 Alan Plutschak, Sr./Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 02/21/11|Federalsburg, MD Hill Crest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee Rousell 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** premoria disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner any o tros Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 I Inknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s performed certificate 1 ☐Yes 2 ☑No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical funeral director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 00053255

State Registrar 31. Date filed (Month, Day, Year) FEB 22 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3683 Choptenk Road Preston MD 21655

Dhysisian
Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - For State Registrar	Otato of Ma	Ce.	rtificate of L		Reg.	1	07404		
	1. Decedent's Name (First, Middle, Last,	Day Year	3. Time of Death							
an al	Patricia Lu	February		2:10 P M						
er	4a. Facility Name (If not institution, give	· ·		4b. City, Town, or	Location of Death		4c. County of Death			
ä	Envoy Nursing Hom			Denton If Under 1 Year	Denton Caroline					
	5. Social Security Number 6. Se	x	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You	ear) 9. Birth	place (State or Foreign intry)		
	Usual Residence of Decedent		0			March 30	1930 Wasi	illigeon, bo		
	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
cţo	Maryland Carolin		1 X Yes 2 □ No							
)ire	10e. Street and Number	. Citizen of What Cou	ıntry?							
al	22304 Butler Cour	t		21629			U.S.A.			
inel	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ∐ Yes 2 ሺ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 💆 No			Specify: W	hite		
g pe	15. Decedent's Edu		16a, Dece	dent's Usual Occup	ation	16	b. Kind of Business/li			
Sete	(Specify only highest grad	ie completed)	(Give	kind of work done of DO NOT use retired	luring most of work			nmunity		
шc	Elementary/Secondary (0-12)	College (1-4or 5-	+)	istrative			resident o	of college		
Ö	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Ma	iden Surname)			
o B	George Fleming				Winnie	Lee				
-	19a. Informant's Name/Relationship (T)	/pe. Print)	19b. Maili	ng Address (Street a	and Number or Rui	ral Route Number, C	City or Town, State, Z	ip Code)		
	Emily Carr / daug	hter	2230	4 Butler	Court; D	enton, Ma	ryland 216	529		
	20a. Method of Disposition		20b. Place of Disponentery, cre-	osition (Name of ematory or other place	e) !	Date 20	c. Location - City or	Town, State		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					15 2011	Chester,	Maryland		
	21. Signature of Funeral Service Licens						Greensbor			
	Med CK	un	F1	eegle and	Helfenb	ein Funer	al Home, I	PÁ		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused	the death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between		
	Immediate Cause (Final	_		COE TOP	MLNT	112	1	Onset and Death		
	Immediate Cause (Final disease or condition resulting in death) a. END - STAGE DEMENTIA Due to (or as a consequence of):							TORIOS		
ner	Sequentially list conditions, lift by least state of the conditions of the condition									
ami										
ledical Examiner	resulting in death) Last	Due to (or as a	a consequence of):							
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Mec	IF FEMALE:	00 1/								
ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year				
ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnant at 9□Unknown	time or death 5	Other (specify)						
P	Part II. Other significant conditions co	ontributing to death bu	ut not resulting in the u	underlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
Be Completed by Physician/M	-	-				1 □ Yes	2 □ No 3 × Pr	obably 4 □Unknown		
lete	HYPERTENSION, CHRONIC OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 Unknown PULMON ARY DISEASSE ATHEROSCLEROTIC 24a. Was an autopsy prior to completion of cause of									
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ပ္သ	CNCDID UAS	e glyk	DISEAS	>1~	26 Place of Dear	th (Check only one)	No 1 ∐Yes	2 No		
o B	examiner?	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	ent 3 DOA Oth	er:		ce 6 □Other (Spec	cify)		
): To	27. Manner of Death	28a. Date of Injur	ry 28b. Time			28d. Describe how				
tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year) Injury		Yes 2 □ No					
ifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inju	ury - At home, farm, s	treet, factory, office		28f. Location (Stre City or Town,	28f. Location (Street and Number or Rural Route Number,			
Sert	1 Tronside	Dunanig, etc	s. (Opeony)			ony or young				
Medical Certification:	29a. Certifier (Check only 2 Medical Exam	/sician: To the best of	of my knowledge, dea f examination and/or i	th occurred at the til	ne, date and place pinion, death occu	, and due to the cau	ise(s) and manner as e and place, and due	s stated. e to the cause(s)		
ledi	one)	and manner sta								
2	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mont			
	Man John	ATTENDI	NG 1MD	DO	N 2 70	' '	1 1 1-1			
	20 Name and address of person who o	ompleted cause of d	eath (Item 23a) (Type	, Print)	DA. ()	Farina	10000	2011 MDZ163Z		
	TAUL II. ICELA	112001) 'm	1 241 DI	-BOMING	NAIN PA	- I EDIZO	INDRATE"	いしんしょうし		

Registrar

State

31. Date filed (Month, Day, Year)
FEB 1 5 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

JOSEPHINE F. 2. Date of Death 3. Time of Death BOWLES POLK 2011 Physician/ Month FEB. 12:35 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WILLIAMSPORT NURSING HOME WILLIAMSPORT WASHINGTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - YF Months Days Hours 235-66-9935 79 6/1/1931 WEST VIRGINIA **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV BERKELEY FALLING WATERS 1 🗆 Yes 2 📈 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 POSTAL DRIVE 25419 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ZORA BABLE BOWLES NORMA CADLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
152 POSTAL DRIVE, FALLING WATERS, WV 25419 BETTY SUE MALONE/DAUGHTER 20b. Place of Disposition (Name of MARCH $\overset{ ext{Date}}{\mathbf{I}}$, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State GREEN HILL CEMETERY MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility d Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Rober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any leading to improve Examine if any leading to immedicause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? 2 200 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has page 2 autopsy performed' death? 2 No 2 🗆 No Yes completed filled in by the funeral director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated only one the 29b. Signature and title of ce 29c. License number D0063233

DHMH 17 Rev 7/2009

State Registrar 580 C Northern

32. Registrar's Signature

Hagerstown MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shahid Mahmood

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Feb. 11, 2011 Year Del Carmen Reyes 1:30p M Maria Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Examiner Silver Spring 1024 Quebec Terrace #103 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Days Hours Min El Salvador Months 870877923 87 214-90-5731 Director Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Funeral Director Silver Spring 1 Yes 2 No MD Montgomery 10f Zip Code 10g. Citizen of What Country? 10e Street and Number E1Salvador 20903 1024 Quebec Terrace #103 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) £1 Salvadoren

Specify: 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname)
 Fermina Alvarez ပ Juan Reyes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13407 Hathaway Drive Silver Spring, Md2090 19a. Informant's Name/Relationship (Type, Print Maria A.Saavedra/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 2/22/2011 20c. Location - City or Town, State Aquas Callente cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State LaŪnion,El Salvador Municipal Cemetery 4 Donation 5 Other (Specify) 21. Sign tuge of Funeral Serv PHILIPADES OF THALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final months Physician/ Metastatic Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and
eted filled in by the funeral director, page 2 should be detached for use as the burlar-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by diabetes melitus, hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medica 26, Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 - Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D61067 Dhysician Feb. 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12520 Prosperity Dr. #320 Silver Spring, Md20904 Laura Khandagle M.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02-11-2011 1:38 a M Gilmar Escobar Reyes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Gilchrist Center Sex 14 M 2 D F **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Min Hours 04-16-1971 E1 Sallvador 39 Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified of 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Lutherville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Winslow Place 21093 El Salvador Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces Completed by 1 Never Married 2 X Married ☐ Yes 2 🗓 No 1 X Yes 2 □ No Specify: salvadoran Baltimore, Maryland 21215-0036 Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction 5th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Transito Escobar Marina Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wifeH Winslow Place Lutherville, Maryland 21093 Susana Iglesias de Escobar_ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) El Salvador Family Cemetery 02-23-2011 21. Sig ture of Funeral Service Live 22. Name and Address of Facility W.H. Bacon Funeral Home. Inc. atticia 3447 14th St. N.W. Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ (ARM) 9 disease or condition Medical resulting in death) r as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes peen Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autops er this certificate had eral director, page 2 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) WSP (4 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ☐ Natural 5 Pending September 19 200 2 Accident Yes Yes 2 No Feil several Investigation 1:30 p M within 24 hours after death

To the Funeral Director:

completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) UNKAMA LAUREL, MO Medical 29a. Certifie 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature title of certifier 29d. Date signed (Month, Day, Year) Folinvary 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar HAMUN

31. Date filed (Month, Day

Charles ST

TOMSON

6701

HARIES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1505 Month VIRGINIA SWLAND 2 ol Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Chesapeake Hospice House Anne Arundel Harwood Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🗷 Days Hours 10-10-1924 Mary Land Director 86 220-16-7709 Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.
Important: If tiem 27 is marked effect than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 🗌 Yes 2 💢 No Anne Arundel Harwood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4338 Old Solomons Island Road 20776 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Fenton Sr. Myers, Myrtle Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne C. Rowland, son 4855 Church Lane, Galesville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Gardens 2/25/11 Annapolis, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final de on Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami requires that the death certificate be executed ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year the Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of b Hospital or Attending Physician; The law r 24 hours after death.
Funeral Director: After this certificate has b leted filled in by the funeral director, page 2 si autopsy performe death? 1 Yes 2 No Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ANDRIN 2 No ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 11CE 28d. Describe how injury occurred 1 Natural 5 Pending HUUSE 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu e and title of certifie 29c. License numb 29d. Date signed (Month, Day, Year) 438 besserva 22 2011 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) Hui 31. Date filed (Month, Day, 32. Registra s Signature State FEB Registrar

DHMH 17 Rev 7/2009

	1- For State	State of Maryla		rtment of tificate of		d Mental H		eg. No.	
Physician/ Medical Examiner	Registrar 1. Decedent's Name (First, Mid Ear1 Ho		lings,	Jr.			2. Date of Dea Month February	ith Day Year	3. Time of Death 0819 hrs
	4a. Facility Name (if not institute Calvert Memorial Ho	ion, give street and nu			b. City, Town, or I Prince Frede			4c. County of Calvert	Death
Funeral Director	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min		`	Birthplace (State or Foreign Country) Marry Land
any	578-76-0347 Usual Residence of Decedent 10a. State 10b. Count		53	Town or Locati	on		1 08-17	7–1957	Maryland 10d. Inside City Limits
	MD Calv	vert			Lusby		·	l0g. Citizen of Wha	1 Yes 2 X No
ith the Maryland 23a or 28s-f show notified at once.	11527 Tomahav				20657			USA	
r death wi or items must be	11. Marital Status 1 Never Married 2 X		2 X No	If Yo	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto		White,	
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours afte nt of Health and Mental Hygione ut: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by	3 Widowed 4 D 15. Decedent's Education (Specific Elementary/Secondary (0-1)	or Dates: Decify only highest grad	de completed)	16a. Deceden	t's Usual Occupationst of working life.	on (Give kind of v		16b. Kind of Busi	White
215-0036 be filed within 72 hour nat Hygiene riked other than "naturent, the Medical Exament, the Medical Exament.	8 17. Father's Name (First, Midd			Floori	ng Contr	actor 8.Mother's Name	(First, Middle,	Floor Maiden Surname)	ing
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygene Important: If item 27 is marked other ti injury or other traumatic event, the Med	Earl Howard		gs, Sr	19b. Mailing	Address (Street	Shirle	ey Anı Rural Route Nu	Hutch mber, City or Town,	
e, MD and 2 sho lealth and 2 item 27 is traumati	Penny Rawling			lace of Dispos	Tomahaw		Lusby Date		57 City or Town, State
<u>트 라 임 분 등 </u>	1 X Burial 2 Cremati 4 Donation 5 Other 21. Signature of Funeral Service	Specify:	on otate		n Nation			l Suitla uneral Ho	
Baltii Departm Importa	23a. Part I. Enter the disease,	3. Tres	aused the death.	8	325 Mt.	Harmony	Lane, (Owings, M	D 20736
Medical laminer	failure. List only one cause Immediate Cause (Final diseator condition resulting in death)	se on each line. se a. <mark>Atherosclei</mark>		ascular Dis					Between Onset and Death
er	Sequentially list conditions, b								
ted 1 ansit Examiner	cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	C.	consequence of):					
iO, e be executed ysician and burial - transit	UNPENDED	AMENDED						23d. Date of d	Jaliyany
P.O. Box 6876 that the death certificate need by the attending phy detached for use as the leached by Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live b	nant at time of dea	2 Fe	tal death 3 [ner (Specify)	Ectopic pregna	ancy	Month	Day Year
P.O. I es that the signed by the be detached by Ph	Part II. Other significant cond	ditions contributing to	o death but not re	sulting in the u	nderlying cause g	iven in Part I.			oute to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/IMedical Certification:					20 Diago	of Dogth (Charle	1 Yes	psy pr	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
Vital Rechysician: The Inthis certificate Indirector, page	25. Was case referred to medi examiner? 1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		of Death (Check Other: A Nursi	ng Home 5		Other:
ion of verding Ph. sath. or: After tithe funeral		28a Date (Month rending vestigation	of Injury n, Day,Year)	28b. Time of I		ry at Work? /es 2 No	28d. Describe	how injury occurre	d
Division of iterating or Attending or Attending or Attending or and Director: Affilled in by the fun iteratification.	3 Suicide 6 Co	28e. Place (Specify)		ome, farm, stree	et, factory, office b	uilding, etc.	28f. Location or Town,		r or Rural Route Number, City
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the Medical Certificatic	29a. Certifier 1 Certifying one) 2 Medical E	Physician: To the best xaminer: On the basis and planner s	of examination ar	ge, death occui nd/or investiga	red at the time, da ion, in my opinion	ate and place, and , death occurred	d due to the cau at the time, date	use(s) and manner a e and place, and du	as stated. ue to the cause(s)
H S H S	29b. Signature and title of cert				29c. Licens			29d. Date signe February 20	d (Month, Day, Year)), 2011
JRW OCME	Mary G. Ripple MD.	on who completed cau Deputy Chief I			W. Baltimore	Street, Balti	more, MD 2	1223	
State Registrar		2 2011 32 P	gistrar's Signatu	P. Asa	ale	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		Mental Hygi	iene		
				ertificate of Death	Re	eg. No. 20	07410	
	Physicia	ın/	Decedent's Name (First, Middle, Last) ONING Decedent's Name (First, Middle, Last)		Date of Death Month	Dov. Year		
	Medic		JONNIE ROGERS 4a. Facility Name (if not institution, give street and number)	1	FEB Month	8 ^{Day} 20 ^{Yea} 5:15 a		
	Examin	er	FOXCHASE NURSING HOME	4b. City, Town, or Location of Death Silver Spring		4c. County of Deat		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birl	hplace (State or Foreign	
	Director		250-36-4673 1 X M 2 □ F 81 Yrs.	Months Days Hours Min.	Dec. 30,	1929 Con	SC SC	
	now at	Ļ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits	
	arylar sa-f s	Director	SC Horry Loris				1 ☐ Yes 2 🛣 No	
	the Mor 28			10f. Zip Code	10	0g. Citizen of What Co		
	s 23a rust b	Funeral	1468 Goosebay Dr.	29569		USA		
	death ritem ner n			Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame		
36	after al", or xami	d by	1x Yes 2 No If Yes, Give 1946 -	1 ☐ Yes 2 🔀 No Specify:	,,	Black, White		
9	hours natur lical E	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	1.	16b. Kind of Business	lack	
218	iin 72 ie. han "; Med	dwo	(Specify only highest grade completed) (Give Blementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of worki DO NOT use retired)	ing	TOD. KING OF BUSINESS	mada y	
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and	ntal H red of	To B	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Surname)		
کّ	ould by Me Me	Ĺ	John C. Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Sarah C		21 T Q T.	0.11	
altimore, Maryland 21215-0036	d 2 sh alth ai 1 27 is ar trau		Too. ma	ing Address (Street and Number or Rura Decatur St. NE W		${\sf n}$, DC 2001		
ore,	of Her of Her fitem	,	20a. Method of Disposition 20b. Place of Disposition	osition (Name of [matory or other place)	Date 2	20c. Location - City or	Town, State	
Ĕ	Page ment tant: I			oln Cemetery 2-18	-2011	Brentwood,	MD	
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2 Name and Address of Facility Fun Marshall-March Fun 4308 Suitland Rd.	eral Hom	e of Maryl	and	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate	
souda,	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cardiopulmonary	Arrest		1	interval Between Onset and Death	
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):					
		ē	Sequentially list conditions, b. Prostate Cancer					
	ed sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury Anemia		3)			
	xecut n and al-tra	Exa	that initiated events resulting in death) Last c. Due to (or as a consequence of):					
09	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical	d					
9/89	tificat ing ph		IF FEMALE:					
Box 6	ith cer	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3			23d. Date of deli		
ň	ne death the atte	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Unknown 9 Unknown	Other (specify)		Month	Day Year	
л. О	that the ned by the detach	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
S,	uires in sigr	ed b			1 ☐ Yes	2 🗖 No 3 🗆 Pr	obably 4 🗆 Unknow <i>n</i>	
Š	iw req	plet			24a. Was an		opsy findings available	
Vital Records,	The Is	Completed			autopsy performe 1 \sum Yes 22	ed? death?	ompletion of cause of 2 No	
<u>.</u>	cian; sertific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		,		
O T	Physical this carral direction	ا ۾	1 ☐ Yes 2 ☐ Yoo ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manual of Death			ce 6 C Other (Special	(y)	
֡֝֟֝֜֝֜֝֟֜֝֝ ֡	tth. : After : fune	cate	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	28c. Injury at work? M 1 Yes 2 No	28d. Describe how	injury occurred		
DIVISION	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		28f. Location (Stree	et and Number or Rura	al Route Number,	
<u>ב</u>	ital or irs afti al Dir led in		building, etc. (Specify)		City or Town, S	State)		
:	To the Hospital or Attending Physician. The law requires within 24 hours after death. To the Funeral Director. After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigations)	tigation, in my opinion, death occurred at	the time, date and i	place, and due to the ca	ause(s) and manner stated	
:	To the vithin To the comple		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	e, and due to the ca	ause(s) and manner as s d. Date signed (Month,	stated.	
	4			D67092		2/11/2011		
	190	-	30. Name and address of person who completed cause of death (Item 23a) (Type, I			2/11/2011		
	٦,		Weihan Wang, MD 15245 Shady Grove	Rd. Rockville,MD.	20850			
	State Registra	-	31. Date filed (Month, Day, Year) Section 32. Registrar's Signature.					
	3,040		1					

State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phyllis Jean Reed 11:05 Medical byvor 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 04, 1930 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min. Country Pennsylvania 578-44-1319 Director Yrs 80 Usual Residence of Decedent artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 North Crain Highway, Apt 932 21061 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗙 No 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 8 0 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည John Knox Margaret Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Reed - Daughter 403 Orchard Road, Glen Burnie, Maryland, 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State February 28 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State **Cumberland Crematory** Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Brandi Wilhelm per dvr 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) sequence of: **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year be detached Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed: 1 🗆 Yes To the Funeral Director; After this certific completed filled in by the funeral director, B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28b. Time of te of injury 28c. Injury at 28d. Describe how injury occurred Natural Accident (Month, Day, Year) injury 5 Pending work' 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 29c. License number Name and person who completed cause of death (Item 234) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 14, 2011 1:30pm M Michael Brian Sepulvado Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 13814 Crosstie Drive Germantown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Months (Month, Day, Year) ct. 19, 1984 1 😾 M 2 🗆 F Virginia 26 **Director** 219-27-2016 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Germantown Maryland | Montgomery 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? r items 23a or iner must be r Funeral 13814 Crosstie Drive United States 20874 filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, th and Mental Hygiene. 27 is marked other than "natural", or ite: traumatic event, <u>the Medi</u>cal Examiner. Black, White, etc. 1X Never Married 2 ☐ Married þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Before and After Elementary/Seconday (0-12) College (1-4 or 5+) Director Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be file and Mental H is marked ot ည Leslie A. Britt Donald Lester Sepulvado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau Leslie A. Sepulvado (Mother) 217 Shorthorn Street, Cedar Park, Texas, 78613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Joseph's Cemetery 2/21/2011 4 Donation 5 Other (Specify) Zwolle, Louisiana 20 Name and Address of Facility DeVol Funeral Home Signature of Euneral Service Gaithersburg, MD 20877 232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition -- Medical resulting in death) Examiner Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been a page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No this certificate 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Hospital: မြ 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1
Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 No Accident Investigation 2011 Unk 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number of) City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Moone 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and discharge the certifying Nurse Practicoper: To the bast of my knowledge, death occurred at the time, date and place and discharge the certifying Nurse Practicoper: To the bast of my knowledge, death occurred at the time, date and place and discharge the certifying Nurse Practicoper: To the bast of my knowledge, death occurred at the time, date and place and discharge the certificity of the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of coft - MD DWE Hankosbury 524 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER mo my 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Donahue Shea 2011 February 11:37 p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick Social Security Number 8. Date of Birth Aug. 31, 1950 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign Days 1 X XM 2 - F Hours Director 60 Indiana 212-54-0772 Usual Residence of Decedent 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9861 Notting Hill Drive 21704 USA · death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: Specify: White "natural", 3 ₺ Widowed 4 □ Divorced Completed Year or Dates traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Menone. Elementary/Seconday (0-12) College (1-4 or 5+) Steamfitter HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kevin Shea Mary Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn Koehler/Step-son 4304 Robert Court, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 **Cremation 3 **D Removal from State cemetery, crematory or other place) Feb. 17 4 Donation 5 Other (Specify) Metropolitan Crematory 201 Alexandria, 21. Signature of Funeral Service Licensee P^{22. Name and Address of Facility}
Francis J. Collins Funeral Home
500 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Laryngeal Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imigury that initiated events Due to (or as a consequence of): e attending physician and ما ثمر نده as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year the detached 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 🕉 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has b director, page 2 s performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 🔼 No Other: Hospice 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🔼 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, 3

State

Registrar

2. Registrar's Signature

7000 Kimmel Road, Mt. Airy, MD 21771

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Diane Rickert CRNP

18

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Formal State Registra MFND#1perMD, 2/24/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Vear Scaldaferri Peter Scaldaferri Medical AKA Februar 201 9:30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Spring Montgomery 8. Date of Birth Jan 29 7. Age (In vrs. last birthday Funeral Year If Under 24 Hrs. 9. Birthplace (State or Foreign Year) 190<u>3</u> 1 XM 2 F Days Hours Country Director 578-10-9562 108 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b County within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 10124 Hereford Place 20901 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify. Specify: White Completed 3 □Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Stone Mason Masonry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F should be Rocco Scaldaferri Theresa Alagia other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 i≰ Rocco F. Scaldaferri/Son 10124 Hereford Place, Silver Spring, MD 20901 t: If item ? 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 2 929/11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify entombment Important: I any injury o Gate of Heaven Cemetery Silver Spring, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University BLvd. W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on the each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) <u>Syncope</u> *Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause Er ter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial transit Failure to Thrive that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 In No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has , aged autopsy performed? Yes 2 2 🗌 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ျ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 \square Pending Accident Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and/or investigation, in my quinton, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D60826 Feb. 17, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State FEB 18 201

Registrar

11-01344 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Russell Smith, III State of Maryland / Department of Health and Mental Hygiene 07415 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day February 17, 2011 III 0708 hrs Medical Examiner James Russell Smith, 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director 216-85-2168 07/03/2009 CountryMD 1 1 X M 2 F Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No , nr items 23a or 28a-f shur r must be notified at once. MD Dunkirk Calvert Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importment of Health and Mental Hygiene.
Importment: If item 71 is marked other than "tastural", ur items 23a or 28a-f sha
injury or inther traumatic event, the Medical Examiner must be notified at once. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 12005 Elsie Lane 20754 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Ricen. etc.) White, etc. 1 X Never Married 2 Armed Forces? 1 Yes 2 X No Specify:Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Never Worked n/a 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) James Russell Smith. Jr. Yhonnie Mvers Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12005 Elsie Lane Dunkirk, MD 20754 19a. Informant's Name/Relationship (Type, Print) ဥ James R. Smith, Jr./father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Cooper's UMC Cem. 1 X Burial 2 Cremation 3 Removal from State 2/28/2011 Dunkirk, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2. Name and Address of Facility Sewell 1 1451 Dares Beach Rd. Funeral Home P.A Pr. Fred.,MD20678 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and (Medical Death Complications of Prematurity Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit sician/Medical AMENDED 23a, 27, per me, g918 8-11-11 sm attending physician a for use as the burial -X UNPENDED Box 68760, IE EEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown ξō 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed this certificate has been all director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes Yes 2 No 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other | Nursing Home 5 Residence 6 Other ٩ 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No 24 hours after death. Tn the Funeral Director: completely filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 18, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Pate filed (Month, Day, Year)

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2011 8:04 Thomas Stallings Leon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Calvert Memorial Hospital Prince Frederick 9. Birthplace (State or Foreign MD Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 1 **X** M 2 □ F 05-05-1934 Director 217-28-8628 76 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 🔯 No Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 179 Main Street 20711 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced White Year or Dates. 1955-56 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction painter and carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Stallings | Pear1 Agnes Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl J. Dowell, niece 14408 Marlboro Drive, Upper Marlboro, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Mt. Harmony Church 02-23-2011 Owings, MD 20736 . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final RSSPIRATORY FAILUAS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** UKEF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury STOUCTUS DULMONANY DISTUR Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2/2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 70,21AL 1+0(1 rson who completed cause of death (Item 23a) (Type, Print) CALVERG PRINCE DEP"

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year EMMA Santilli 1230 07 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death University of Morgland Medical Center Baltinor Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 💢 F Days Feb 15. 91 **Director** 577 - 11 - 2075 **Virginia** Usual Residence of Decedent id Mental Hygiene.
s marked other than "natural", or items 23a or 28a-1 511s marked other than Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryalnd Prince George's District Heights 1 Yes 27 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1813 Benson Lane 20747 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 TNO Specify: Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of ၉ Millard Fillmore Sanford Edna Lee Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Diana L. Maus (daughter) 2175 Kay Hill Drive, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 🗚 urial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery Feb 21, 2011 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service Licenses m012 Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, clock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sepsis Medical Due to (or s a consequence of): Examiner weekis Intra-obdominal infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consequence oil. complication of that the death certificate be executed adhesions and abdominal active energym -tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P n 24 hours after death. e Funeral Director: After the felled in by the funeral Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined on 24 hours
on the Funeral Dr
completed filler Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2011 100796 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeremiah E. Pelmos S. Orea 22 Baltimor OM c 5+, 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 23 2011 Physician/ February 5:00 Edith Pauline Shank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Retirement Village Williampsort Washington County 8. Date of Birth Feb. 17 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F 1915 Marviland 220-16-1250 96 Director Usual Residence of Decedent show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho inty or or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Williamsport Maryland Washington County 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 154 North Artizan St. 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🎇 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Beauty Salon 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Deal Etta Stoops Deal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Nancy Mongold-daughter 220 South Potomac St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Broadfording Church Cem 2-28-2011 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown,MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PNEWMONIA WEEK Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year sate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENDSTAGE SENTLE BEMENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 유 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2-23-11 3700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-5 Artiza Williamson 31. Date filed (Month egistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07:40 February 22 2011 Gerdes Smith Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington 1604 Woodlands Run Hagerstown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M M 2 □ F Director 090-24-1246 95 07/21/1915 New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show the Medical Examiner Loast be notified at 1 XYes 2 □ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number items 23a or by Funeral 1604 Woodlands Run 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐Yes 2 No Specify. Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any Injury or other traumatic event, to W. dec. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Advertising Executive Advertising Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerdes ပ Ralph R. Smith, Sr. Edna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1423 The Terrace, Hagerstown, Maryland 21742 Cheryl Strong / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 2/25/2011 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S.Men 1601 Pennsylvania Ave., Hagerstown, MD 21742 fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Oneet and Death 23a. Part1. Enter the disease, or complete shock, or heart failure. List only on Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (of as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 ☐ Yes 2 🗗 📈 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 20 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After **Division** 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature an 29d. Date signed (Month. Day, Year) on who completed cause of death (Item 23a) (Type, Print) OH6-0+1 Year 2 31. Date filed (Month egistrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harry Leroy SHOCKEY 1250 PM FEBRUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. Social Security Number 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral (Month, Day, Min. 1 🛣 M 2 🗆 F 81 Director 212-24-7153 <u>Maryland</u> Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1218 Wabash Avenue 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married Completed by 1 Yes If Yes, Give 2 X No Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) food vending company maintenance supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ruth Irene Hamby Harry Hezekiah Shockey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1218 Wabash Avenue, Hagerstown, Maryland 21740 Rosalie M. Shockey - wife Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State Cedar Lawn Mem.Park 2/24/2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has b lirector, page 2 s autopsy perform 1 Tes 2 No Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 2 1 🗌 Yes 1 Inpatient 2 💆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28a. Date of injury Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH-3

State Registrar

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 2 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February Physician/ Michael Alphonso Starks 16. 2011 12:37 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year)
Dec. 25, 1953 Social Security Number 9. Birthplace (State or Foreign Country)
South Carolina 6. Sex **Funeral** 7. Age (In vrs. last birthday) Months 1 🖾 M 2 🗆 F Director 579-72-0989 57 Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 X Yes 2 No Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7955 Ouill Point Drive 20720 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Self-Employed Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be filed and Mental H Thomas Starks Mary Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S ye 1 and 2 sh t of Health a Cortesa Marshall - Life Partner 7955 Quill Point Drive Bowie, Maryland 20720 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland
Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of I Important, If is any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Stewart Funeral Home, Inc. licensee 001 Benning Road NE Washington, DC 23a. Part 1 Ent. r the disease, complications that caused shock, or blart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acute Myocardial Infraction Medical Examiner Due to (or as a consequence of) Multi Organ Failure Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of law requires that the death certificate be executed Pneumonia sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical phy use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No į Pregnant at time of death Month Dav Year signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed or Attending Physician: The 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending s after death. Accident Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral L Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 29c. License number

Registrar

Box 68760

P.0.

Division of Vital

1500 Forest Glen Road

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kshama Garg, M.D.

31. Date filed (Month, Day, Year)

FEB 2 3 2011

D60826

Silver Spring, Maryland

February 17, 2011

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 12:00 P M Medical Beulah Scott February 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard 5510 Harvest Scene Court Columbia If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Virginia 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Director 97 579-05-8586 Dec. Usual Residence of Decedent 23a or 28a-f show 10a. State 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5764 Stevens Forest Road 21045 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Armed Force 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other two...... 12th Homemaker Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edgar Christian Sarah Waller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104519a. Informant's Name/Relationship (Type, Print) Dolores Washington - Niece 5764 Stevens Forest Road # 224 Columbia, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Landover, Maryland ature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1 arter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate he imers Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes H99110 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending work? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific MP 30. Name and address of person who completed cause of death (item 23a) (Type, Print) (03 6334 910 Ledai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Vital

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-17626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Elizabeth Mable Strawser O Shooth 350 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Health System Cumberland **Allegany** If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours June 13 1942 Country) Director MD. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than ".... any injury or other terms." 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD. 0akland Garrett 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1595 Spring Glade Road 21550 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 K Married 1 ☐ Yes 2 No Specify: Specify:White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Store Clerk Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Chilcoat Marvin Elizabeth Julie Barringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oscar V. Strawser 1595 Spring Glade Rd. Oakland, MD. 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Deer Park Cemeterv 2/18/11 4 ☐ Donation 5 ☐ Other (Specify) Deer Park MD. . Signature of Funeral Service Licens 22. Name and Address of Facilit D. A Burdock Funeral Home, P.A. 21 N. 2nd. St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Aurtic Value Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Duri to (or as a consequence or) attending physician and for use as the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signed by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an monin within 24 hours after death.

To the Funeral Director: After this certificate he completed filled in by the funeral director, page performed? Yes 2 No Hypertensin 2 No 1 Tyes 25. Was ase referred to medical Be B 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes မ 1 Minpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 7/2009

Broadwai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

31. Date filed (Month, Day, Year)

21244

21532

Frostburg

11-01529 Carmelo Santiago Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

armelo Santiago	1- For State Certificate of Death	7425		
Physician/ ledical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year	of Death		
AEGICAI EXAMINICI	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace	(State or		
Director	158-78-5666 1☑M 2□F 29 Yrs. Months Days Hours Min. 05/19/1981 Foreign Country)	NJ		
any	Tour out	side City Limits		
Maryland 28a-f show d at once. ector	MD Ceci EKton 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yes 2 No		
ath with the Maryland items 23a or 28a-f about be notified at once on Director	10e. Street and Number 234 Hollings Worth Manor 21921 USA			
leath with r ritems 23, rust be not uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indi White, etc.	an, Black,		
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5-0036 led within 72 hour flygiene. other than "natt the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Upholsterer Boating			
imore, MD 2121; Pages I and 2 should be fil ment of Health and Mental I tant: If item 77 is marked or other traumatic event; TO Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Collings Worth Manor, Elkton MD			
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	20a. Method of Disposition 20b. Place of Disposition (Name of cametery, Date 20c. Location - City or Town, S	itate		
Baltimore, permit. Pages I ar Department of Hegin portant: If ite mjury or other tr		リ		
Balti permit. Departm Importu injury o	Vant of Strang Feeley Family Newark DE			
Physician	failure. List only one cause on each line. Mixed Drug (Methadone, Oxymorphone and Alprazolam)	een Onset and Death		
Examiner	or condition resulting in death) Due to (or as a consequence of):			
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Box 68760, e death certificate by the attending physic ed for use as the buthy sician/Mee	IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year		
b. Box 6i the death cert by the attendii ched for use a Physicia				
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ords, P.C. w requires that s been signed should be deta		ndings available		
Division of Vital Records, tal or Attending Physician: The law requires rs after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	autopsy prior to completic performed? death? 1 ✓ Yes 2 No 1 ✓ Yes	2 No		
Vital Recysician: The I his certificate by director, page	25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 17			
ing Physi ing Physi After this funeral dii	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred			
Division of ital or Attending urs after death. urs after death. ral Director: After lied in by the fune. ertification:	Natural 5 Pending Investigation Fd 2-24-11 Fd 0650hrs 1 Yes 2 x No subject ingested media 2 x Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri Medical Certification: To Be Completed by Physician/Med		(s)		
To roo	(1,1)	Year)		
	O.C.M.E. February 25, 2011 30. Name and address of person who completed cause of seath (Item 23a)			
	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			
State Registrar		·		

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death John Ronald Sigafoos February 16, 2011 9:57 AM M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min 1√2 M 2□ F 195-20-9680 81 Feb. 11, 1930 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Jefferson 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3903 Shadywood Court 21755 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XXX es 2 □ No If Yes, Give Year or Dates: N/A 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cartographer/Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Sigafoos Mabel Stahl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jayne R. Hopwood, daughter 3940 Southview Court, Jefferson, MD 21755 20a. Method of Disposition

XXBurial 2 □Cremation 3 □Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State St. Paul's Cemetery Feb. 19, 2011 Jefferson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Live ee 24Keeney Address Bastord PA Funeral Home Kir M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung Conun disease or condition resulting in death) Due to (or consequence of): Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed?
Yes 2 1 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be

Physician /Medical Examiner Examiner

Important: If it any injury or c Department of

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items

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Director

Funeral

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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

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Maryland

Baltimore,

Pages 1

the burial-tran the death certificate be page 2 s certificate or Attending Physician: this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

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Completed by Physician/Medical Be Certification: To

Medical

2 Accident 3 Suicide 4 ☐ Homicide

29a Certifier

29b. Signature a

31. Date filed (Month, Day,

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 0 006 2223

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

February 16, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PREDEUCE, MD 2170 4.

State Registrar

To the Hospital o within 24 hours aft To the Funeral Di

State of Maryland / Department of Health and Mental Hygien Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 4 2011 2040 Laurence Sharpe M 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Shady Grove Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, eb. 9, Days Hours Min. Illinois 355-10-1273 89 **Director** Feb. Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Important; or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical 10d. Inside City Limits with the Maryland Director Maryland Washington County Smithsburg 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13763 John Cline Rd. 21783 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces

1 X Yes 2 If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. Completed by 1 Never Married 2 X Married 2 No Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Naval Officer U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H မ Harry Sharpe Bertha Potash Sharpe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13763 John cline Rd. Smithsburg, MD 21783 Blanche Sharpe-wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 2-9-2011 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Kaill 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hemorrhagic disease or condition resulting in death) Medical Examiner 0 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury irr hosis the attending physician and hed for use as the burial-transit river Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year 1 Yes 2 9 Unknown 2 No been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown r this certificate has been sireal director, page 2 should h 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural injury 5 Pending Investigation 2 Accident
3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contifying Nurse Practice of Table 2011 from investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier Mens D0061386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 Sonia John MD 9901 medical 31. Date filed (Month, Day, Year) 32. Regi yer's Si A tyre MAR 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 16 11:08am Carol F. Takahashi 2071 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sunrise Assisted Living-Silver Spring Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 □ M 2 🎗 F 0870771927 **Director** 83 216-50-2671 Ja<u>pan</u> Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director or 28a-f 1 Tes 2 X No Maryland Silver Spring Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 3116 Gracefield Road, Apt. #320 20904 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🖾 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Asian Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Cooking Instructor Open University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Yoshiro Urata Owari Urata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Y. Takahashi - Spouse 3116 Gracefield Rd., Apt. #320, Silver Spring. MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Lincoln Crematory: 02/18/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ft.\ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, HO #1070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. nset and Death Month Immediate Cause (Final Physician/ Failure to Thrive disease or condition Medical resulting in death) Examiner Advanced Dementia of Alzheimer's Type Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Chronic Kidney Disease 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hupertension 24a. Was an autopsy DM Type 2 Depression 1 ☐ Yes 2 🗓 No 1 Yes 2 No Division of Vital 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Be 26. Place of Death (Check only one) Assisted 1 ☐ Yes 2 💢 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 \square Homicide determined Medical 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 10 gWV D53367 February 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

9801 Georgia Avenue, #117, Silver Spring, MD 20902

M.D.,

Shuamsundar Rajan,

31. Date filed (Month, Day, Year)

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A/illiam	Tacker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day February 15, 2011 Year 1427 hrs Madical Examiner William Ray Tasker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Oakland Garrett If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD. Months Days Hours Jan. 25, 1940 Director 220-34-1867 71 1 M 2 F Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No Garrett Mt. Lake Park l other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene, tattiff it east 77 is marked other than "natural", or items 33a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e Street and Numbe 10f. Zip Code 107 Roanoke Ave. Apt. 2 A 21550 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married If Yes, Give Year 1963 - 19681 Yes 2 X No specify: Specify: White 4 X Divorced 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Coal Miner Coa1 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orval R. Tasker Isabelle Bernard Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 2 A Mt. LakePark, MD. Mike Tasker (son) 107 Roanoke Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) permit. Pages 1
Department of H
Important: If i 1 Burial 2 Cremation 3 Removal from State 2/19/11 Deer Park Cemetery Deer Park, MD. 4 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility D.A. Burdock Funeral Home, P.A. 21 N. 2nd. St. Oakland, MD. 21550 23a. Part I. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 虿 1 Yes 2 No 3 ✔ Probably 4 Unknown Lung disease Completed 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? 1 🗸 Yes ✔ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 1 V Natural 1 Yes 2 No Pending the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City filled in by 3 Suicide Could not be determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number O.C.M.E. February 16, 2011 0 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan MD 31. Date filed (Month, Day, Year) FEB 17 2011

DHMH 17 Rev 1/2001

State Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0^{Month} 2011 рM 2:00 Tasker Lillian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Mt. Lake Park 509 Oak Street 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours 08 08 1928 Director 82 218-68-2646 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mt. Lake Park MD Garrett 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 TISA 509 Oak Street hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Zalemma Rotruck permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic of Webster Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 Oak Street, Mt. Lake Park, MD 21550 Vernard Tasker-husband Baltimore, 20b. Place of Disposition (Name of near netery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 3/2/2011 Potomac State Forest Deer Park, MD 4 ☐ Donation 5 ☐ Other (Specify) A Funeral Service 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 100 12 disease or condition resulting in death) lans Medical Examiner Sequentially list conditions, if the last cause. Enter Underlying Cause (Disease or linjury Due to for as a conse vience of Examin and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🗶 No Month Pregnant at time of death Day Year Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed be det b 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has blirector, page 2 s perform CVA Yes 2 X No 1 Yes 2 🗌 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 KINO Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie H0064705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Porter, D. O., 311 North Fourth St, Suite 1, Oakland, MD 21550 31. Date filed (Month, Day, Year) **HAR - 1** 2011 State Registrar

11-01108 Elizabeth Velez-V	'asc	Please Type or Prin	t in Black In	delible artment	ink. E	n <mark>sure All Copi</mark> e h and Mental H	es Are Leg lygiene	ible.	071.21
	<u>F</u>	- For State		tificate				, No. ZUII	0 7 4 3 1 3. Time of Death
Physician Medical Examin		Decedent's Name (First, Middle,Last) Elizabeth Vel	ez Vaz	quez			Month February 9	Day Year , 2011	0005 hrs
		la. Facility Name (if not institution, give street ar 1018 Quebec Terrance Apt 104	nd number)			own, or Location of Deat Spring	h	4c. County of Death Montgomery	
Funeral Director		is Social Security Number 6. Sex	7. Age (In yrs. Ia		If Under	r 1 Year If Under 24Hr Bays Hours Mir	_	(MM/DD/YYYY) 9. Birth 1 9 7 8 Foreign Cou	nplace (State or
any		Jsual Residence of Decedent 0a. State 10b. County		Town or Loc					10d. Inside City Limits
	힐	MD Montgomery Oe. Street and Number	Sil	ver S	Sprin 10f. Zip		I10	g. Citizen of What Coun	1 Yes 2 No
the Mari	2	1018 Quebec Terra	ce #104			20903		Mexico	
17215-0036 Ided within 72 hours after death with the Maryland fential Hygiene. narked other than "natural", or items 23a or 28a-f sho rent, the Medical Examiner must be notified at once.	Fune	1 Never Married 2 X Married Arm	Decedent Ever in U. ed Forces? 'es 2 X No	ı		nt of Hispanic Origin? (S y Cuban, Mexican, Puerto No specify:	o Rican, etc.)	14. Race - Americ White, etc. Wh Specify:	ite
ours afte	<u>8</u>	15. Decedent's Education (Specify only highes		16a. Deced	lent's Usual	Occupation (Give kind of king life, DO NOT use re	work done	16b. Kind of Business/In	ndustry
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MD 21215-0036 d 2 should be filed within 7 in and Mental Hygiene. In 27 is marked other than unatic event, the Medical control of the control of the medical con	Be	7. Father's Name (First, Middle, Last) Gregorio Velez Sa				Bertha	_	ez Perez	
AD 21 2 should b and Me 27 is ma	ᄋ	9a. Informant's Name/Relationship (Type, Print Gregorio Velez Sam		19b. Mail	ing Address 08 Fr	(Street and Number or ancis Dri	Rural Route Numb ve Silv	er, City or Town, State, er Spring	, Md20902
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatte event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Remo 4 Donation 5 Other Specify.		rematory or IN1C1]	otherplace)	emetery		^{20c} Location - City or ¹ Santiago Nativitas Mexico	
Baltil permit. Departm Importa	ľ	21. Signature of Funeral Service Licensee	2			Rodre of Radin ALI Columbia			
Physician / Medical	1	23a. Part I. Enter the disease, or complications to failure. List only one cause on each line.		. Do not ente	r the mode o				Approximate Interval Between Onset and Death
Examiner			ia and Sharp Fo as a consequence o		es				Deatri
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fuorent Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		3b. Was decedent pregnant in the past 12 months?	yes, outcome of preg live birth Pregnant at time of de Inknown	2	Fetal death Other (Spec	3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Year
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	on: T	27. Manner of Death 28a. 1 Natural 5 Pending FO	Date of Injury Month, Day,Year) JND: 0 9, 2011	28b. Time of FOUND: 0005 hrs	of Injury 2	28c. Injury at Work? 1 Yes 2 No	28d. Describe h Subject assa	ow injury occurred ulted	
Divisi pital or Att ours after de ceral Direct filled in by	Certificati	3 Suicide 6 Could not be determined	Place of Injury - At he			office building, etc.	or Town, St	treet and Number or Rur ate) Ferrance Apt 104, Sil	
Divisior To the Hospital or Attend within 24 hours after death To the Fuoeral Director: completely filled in by the	ल्	29a. Certifier 1 CertifyIng Physician: To the cone) 2 Medical Examiner:On the b	e best of my knowled asis of examination a	ge, death oc	curred at the	time, date and place, an opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as state and place, and due to the	d. cause(s)
Touch State of State	ĕ ¥	and man	ner stated.	//	290	License number O.C.M.E.		29d. Date signed (Mon February 9, 2011	th, Day, Year)
		30. Name and address of person who completed					ND 24222		
Sta	te	31. Date filed (Month, Day Year)	edical Examiner Registrar's Signate		. Baltimor	e Street, Baltimore	е, МЮ 21223		
Registr		FEB 17 2011	Brown &	I. ARE					OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Christina Physician/ Valkanas Feb. 13, 2011 5:05рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12906 Wexford Park Clarksville Howard If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth Funeral Age (In yrs. last birthday) 1 □ M 2 🛂 F Days Hours Min 8/975971925 Greece 214-90-0329 85 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10a. State MD 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Howard Clarksville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 12906 Wexford Park 21029 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Vasiliki Valkanas Spiro Kyriazis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12906 Wexford Park Clarksville, Md. 21029 William Valkanas/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 2/15/2011 Silver Spring, Md _5 ☐ Other (Specify) 4 Donation PHTETP Des REMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 21. Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ End stage liver disease Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 XNo Month Day Year certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital Other: 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ြု 1 Tes After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No XNatural 5 Pending 2 Accident 3 Suicide Investigation within 24 hours after deatl To the Funeral Director; completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number D57722 29d. Date signed (Month, Day, Year) Feb.14,2011

State Registrar 1838 Greentree Road #300 Baltimore, Md 21208

M.D.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leonard Richardson M.D.

FEB 17 2011

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrar AMEND#20loper FH2/28/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death February 05 Physician/ 6:30a M A. Valdez 2011 Jose Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F Months Days Hours Min. Month Pay 19943 Country lippines 622-42-8465 67 Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 Yes 2 X No Gaithersburg Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 Philippines 8108 Irwell Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Filipino Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Lobbying Office Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maria Andaya Sabino Valdez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Lillian Valdez - Spouse 8108 Irwell Court, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Ukи -Date 1 Burial 2 X Cremation 3 Removal from Staff Fairfax, Virginia Fairfax Crematory Feb. 24, 2011 21. Signature | f Fun-in | S | ice | | n ee 22. Name and Address of Facility Everly Community Funeral Care 6161 Leesburg Pike, Falls Church, VA 22044 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Pnysician/ Failure inuxes disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner neumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burial transit Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cancer 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, and the funeral director, the funeral director, the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 400 1 Yes မ 1 Impatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 medical dar Dr

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Wei 31. Date filed (Month, Day, Year) mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 15, 2011 9:56 p Donald Aloysius Virtue Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda Social Security Number 8. Date of Birth Jan 24, 1934 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Days Min. Hours Country) PA Director 206-26-1343 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎦 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11308 Ashley Drive 20852 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black, White, etc. 1 □XYes 2 □ No
If Yes, Give Korean
Year or Dates. Conflict þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ^{Specify}White Completed 3 k Widowed 4 Divorced marked other than "natur matic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Military U.S. Government th and Mental Hyg. æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Patrick Virtue Elizabeth Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew D. Virtue/Son 11308 Ashley Drive, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2/19/11 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) George Washington Cemetery 4 Donation 5 Other (Specify) Adelphi, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Eachity Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Anoxic Encerhalopathy Medical resulting in death) Due to (or as a consequence of): **Examiner** Cardiogenic Shock Sequentially list conditions, if any leaf cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (un as a consecuence of sician and burial-transit Physician: The law requires that the death cerlificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year ed by the 9 Unknown g 🗌 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ischemic Cardiomyopathy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Chronic Kidney Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 2 K No Other: 1 🗌 Yes မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle o 29c. License number 29d. Date signed (Month, Day, Year) 10 D59980 Feb. 16, 2011 of person who completed cause of death (Item 23a) (Type, Print) Sandra Delistathis, 8600 Old Georgetown Road, Bethesda, MD 20814 MD

State

Registrar

31. Date filed (Month, Day,

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DHMH 17 Rev 1/2001

State Registrar Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 February Orville Joseph Vandermause Medical 4・37 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood At Crumland Farms Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Days Hours Wisconsin July 8, 1921 Director 579-42-6052 89 Usual Residence of Decedent 28a-f shov 10b. County within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code Funeral 7407 Willow Road 21702 United States 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 1 / 1 Black, White, etc. ş 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 143-146 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Martin 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Salesperson Life Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 August Vandermause Ida Depas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Kessinger / Daughter 8604 Old Brompton Road, Chesterfield, VA 23832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchati. 1 ☐ Burial 2 ☐XCremation 3 ☐ Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Smithsburg, Maryland 21. Signature of Funeral Service Licen Keeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 MO1473 23a. Part 1. Enter the disease complications that caused shock, or heart failure. Let only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ere brougs calor accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): Examir Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Yes 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autops, performed 2 N No death? Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Hospital: 1 Yes ည Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury accurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 009689 slin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Austin Pearre <u>300 W. Ninth Street, Frederick, Maryland 21701</u>

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DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For
State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eloise Story Wagner February 2011 9:50 A. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Gaithersburg Wilson Health Care Center Montgomery 8. Date of Birth
(Month, Day, Year),
Sept. 27,1912 If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔯 F Hours New York Director 183-26-6060 98 Usual Residence of Decedent show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖾 Yes 2 🗌 No Montgomery Gaithersburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Russell Avenue, # 623 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Completed 3 X Widowed 4 □ Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Medical Medical Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even ပ္ Story Charles Eloise Decker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwight L. Wagner/Son 6517 Pullhook Lane, Fayetteville, PA. 17222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2/16/2011 Metropolitan Crem. Alexandria, Virginia 22. Name and Address of Facility ature of Funeral Service Licenses DeVol Funeral Home East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying rate has been signed by the attending physician and page 2 should be detached for use as the burial-fransit esophagetex that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 moviths?
1 Yes 2 No Pregnant at time of death 1 Yes 2 U 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 2 ■ No 3 □ Probably 4 □ Unknown 1 Yes Las 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day Year) H. Robert De

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Box 68760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14. ROBERT DIRSCHBACIY

201 RUSSELLAVENUED

641+HERSBURG, MB 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05:55 A M February 2011 homas Patrick /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washinaton 9522 National 100 Bia Birthplace (State or Foreign Country) If Under Tyear | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days 220-58-4491 59 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 1 ☐ Yes 2 No Washington tool **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 9522 National 21711 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No 3altimore, Maryland 21215-0036 Specify. Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State of MD Elementary/Secondary (0-12) College (1-4or 5+) officer Correctional grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick Walsh May James Virginia ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Big Pool, MD 21711 wife Pike acalyn K. Walsh National 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parkhead Cemetery 2/28/2011 Big Pool, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thompson Funeral Home, Inc Donald Edwin Thompson Funeral Home, Inc P.O. Box 310 Clear Spring, MD 21722 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final mblasto Physician 10 months disease or condition resulting in death) /Medical Pue to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 5 Other (specify) 24 hours after death. • Funeral Director: After this certificate has been signed by the setely filled in by the funeral director, page 2 should be detached i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 🗌 Yes 2 Z NQ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 12 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 17H-10 32. Pristrar's Signature

Registrar DHMH 17 Rev 1/2001

State

2 Yea

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For	Plea	ase Type or State o		nd / Dep	artmen	t of H	lealth		All Copie ⁄lental Hy		_	jible.	071	0.0
Physicia	n/	State Registrar 1. Decedent's Name				Ce	rtificate	of D	eath		2. Date of De			Year	3. Time of	
Medic Examin	al er	Ronald Howard Wiseman 4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital						4b. City, Town, or Location of Death Takoma Park				ary 19, 2011 6:40 PM 4c. County of Death Montgomery				
Funeral Director		OF 16 1000 1₩40□E			7. Age (In yrs. I	last birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bir (Month, Da December	(Month, Day, Year) Cou			hplace (State o intry) verly,	
Maryland 28a-f shov otified at	irector	^{10a. State} Maryland	•	vn or Location tsville									ty Limits			
ath with the ems 23a or r must be r	Funeral Director	10e. Street and Nun 7742 Fr 11. Marital Status			dent Ever in U.	S. 13.	10f. Zip	2	0784		ecify Yes or No-		US		untry?	
urs after de tural", or ite al Examine	ğ	1 ☐ Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No If Yes, Give VIETNAM					13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				Rican, etc.)	Black, White, etc. Specify: White			e, etc.	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Spe	cify only high	ent's Education est grade completed) College (1- 2	-4 or 5+)	(Give	dent's Usua kind of wor OO NOT use rey Pa	k done d retired)	uring mo		ing	1		usiness I	-	
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Physician/ Medical Examiner		Immediate Cause disease or conditio resulting in death)	Final	a. 51	or as a conseq	uence of):	mel	Lit	745						Onset and I	
(a) M (b)	lical Examiner	Sequentially list co if any search of any search cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rhying iinjury s	c. Due to (of as a conseq	Hens	nei									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?		Birth 2 Fet	aldeath 3	Ectopic p		у					ate of deli		Year
quires that the series of signed by ruld be deta	ed by Pi	Part II. Other signif	ficant conditi	ons contributing to d	eath but not res	sulting in the	underlying o	ause giv	en in Par	t I.					the cause of d	
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Attending r death. ector: After by the fune	Certificate:	1 Natural 2 Accident 3 Suicide 4 Homicide	5 🗌 Pendi	ng (Moni igation I not be 28e. Place	th, Day, Year) of Injury - At he	injury ome, farm, st	м	work	Yes 2			Street and	d Numb	-	al Route Numb	per,
lospital or hours afte uneral Dir ed filled in l	Medical Ce	29a. Certifier 1	Certifyin	g Physician: To the base	est of my know	rledge, death	occured at	the time,	date and	d place, ar	City or Ton	ause(s) an	d mann	ner as sta	ited.	inner stated
To the H within 24 To the F	Me		Certifyin	g Nurse Practioner:	To the best of m		death occur	red at the License	time, da number	te and pla	ce, and due to the	he cause(s	and m te signe	anner as	stated.	//
W		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregory C. Mathews, MD, 6410 Rock ledge Drive #410, Bethesda, MD 20817														
Stat Registra		31 Date filed (Mont	Day Year)	Jenera 32. R		the state of the s		-71	74 1			/				

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	•	For State Registrar	State of M	-		artment of F tificate of D			giene Reg. N2 0 1	07440	
Physicia	n/	Decedent's Name (First, Middle)	, Last)					2. Date of Dea Month		3. Time of Death	
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Examine	er	St. Thomas More		mρ	4b. City, Town, or Location of Deat Hyattsvill			5	4c. County of D	George's	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birti	hday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h g.	Birthplace (State or Foreign	
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Aaryla 8a-f s tified	Director	Maryland Princ	e George's				Hyattsvi	11e		1 X Yes 2 ☐ No	
a or 2 be no		10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?	
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d be fi	မ	Ernest	Washngton	Sr.			Gen	radlene	Halman		
should and N is ma auma		19a. Informant's Name/Relationsh	ip (Type, Print)							Zip Code) 20747	
and 2 Health Sm 27 sher tr		Rita Williams -	- Daughter				· · · · · ·			ville, Md.	
age 1 int of 1 t: If its		1 Burial 2 Cremation		cemeter	y, crem	sition (Name of patory or other place	^{e)} Feb. 20	23,	20c. Location - City		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (S		Lee'		rematory Name and Addres			uneral Hom	Maryland	
permit Depar Impor any ir		Namal.	De Ja	UT XI	_				nington, D		
		23a. Part i Enter the disease, or shock, or heart failure. List o	complications that caused	d the death. Do n	ot en te	r the mode of dying	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Between	
hysician/		Immediate Cause (Final disease or condition	- Altero	schevoli	·c	Cardio	Vascula	r de	sease	Onset and Death	
Medical Examiner		resulting in death)	Due to (or as	a consequence o	of):			•			
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e law e has b ge 2 s	Completed	1typo	wywids	om				24a. Was a autop perfor	sy prior death	autopsy findings available to completion of cause of	
an: Th tificate or, pa	Be C	25. Was case referred to medical	$\overline{}$			26. Pla	ace of Death (Checi		2 No 1 🗆	Yes 2 No	
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ospita hours ineral	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge, o	death o	ccured at the time,	date and place, an	d due to the cau	use(s) and manner as	stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Mec	only one) 3 Certifying	xaminer: On the basis of ex Nurse Practioner: To the			eath occurred at the	time, date and place			ne cause(s) and manner stated as stated.	
₩ ¥ 1 00 0		29b. Signature and title of certifier	210			29c. License	number 6 3 6 8		29d. Date signed (<i>Mc</i>	onth, Day, Year)	

State Registrar

DHMH 17 Rev 7/2009

Ajit Kurup, M.D. 1835 University Blvd. # 208 Hyattsville, Maryland 20783
31. Date filed (Month, Day, Year)
32. Registrar's Signature
FEB 2 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 00.37AM 2011 Kevin Cephas Whitley Feb Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Medical Center Prince George Fort Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Oct. 20 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Virginia 1 X M 2 Director 223-90-3378 48 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Fort Washington Prince George 1 Yes 2 No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20744 8708 Devon Hills 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 X Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: B<u>lack</u> 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Is 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Transit Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tries Whitley Gracie Spratley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9288 Thomas Park Lane Smithfield, VA 23430 Whitley(Mother) Gracie 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation 2/21/2011 Hampton, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Shivers Funeral Chapel May E. Hetgrom M0137 12749 Courthouse Hwy.Smithfield, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final DISCAN Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (ur as a consequence of, that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death signed by the a g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 known Division of Vital Records, The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ this funeral 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral Natural (Month, Day, Year) 5 Pending 1 Tes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Patrick Daly
31. Date filed (Month, Day, Year)
FER 2 3 2011

11711 Livingston Road Fort Washington, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10.50 AM MILDRED WEDGE FEB. 6 kg 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George Laurel Health of Rehab Politicent River 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 □ M 2 🕱 F South Carolina 1.920 Director 577-28-6108 90 July 8, Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show event, the Medical Examinar must be notified at 1⊠Yes 2 No Director College Park 28a-f Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö or items 23a Funeral 20740 5960 Westchester Park Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 🔼 No Specify: à 3 Widowed 4 ☐ Divorced natural", American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Item Office Clerk Hecht Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Saunders (unknown) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 19a. Informant's Name/Relationship (Type. Print) Anita Cary - Daughter 5960 Westchester Park Drive College Park, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Washington, DC 2011 22. Name and Address of Facility 21. Signature of Furreral Servi Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 Approximate Interval Between Onset and Death 23a. Part S. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Years Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause Universe or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed ician and burial-tran Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the. attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day Pregnant at time of death 5 Other (specify) 9 DUnknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No nours after death neral Director; / filled in by the fi 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🛮 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier John . 1715 MD Feb. 2011 53411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shesadri # 210 20715 Gallant Fox Ln Bowie

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

garles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Johnny Mack Walker 2011 500 February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Prince George's Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) June 24 **Funeral** 9. Birthplace (State or Foreign 1 🛚 M 2 🗌 Months Min. **Director** North Carolina 239-88-8318 60 Usual Residence of Decedent nan "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17-42nd Street NE 20019 #10 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married δ 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: African Completed 3 Divorced 4 Divorced Year or Dates Amerian 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Supervisor of Production Private Be arthit. Page 1 and 2 should be filed egrartment of Health and Mental Hyportant: If item 27 is marked out by Injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Walker Sr. Willie Ellison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene M. Jackson - Wife 110 36th Street NE Washington, DC 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Feb. 2211 cemetery, crematory or other placel 1 Durial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland pertrit. I Derartm Importa any inju 22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral St 4001 Benning Road NE Washington, DC 23a. Part 15 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shool, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ FATAL CAFDIAC ALLHYTHMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe After this certificate 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) 2 **N**No Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 1 Natural 5 Pending Accident Director: / Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined hin 24 hours a the Funeral D npleted filled i Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On trig basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practionary to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 3105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEDER MD IRVING ST NW #308 31.*Date filed (Month, Day, Year) State 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 7 4 4 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert Ernest Whetzel February 21 2017 9:50 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 112 Walnut St. Westernport United States Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 1, 1940 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hou*rs* 213-40-6913 70 West Virginia Director Usual Residence of Decedent 3a or 28a-f show t be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD Allegany Westernport 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Walnut 21562 United States 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Forces Black, White, etc Completed by 1 Never Married 2 Married 1xxYes 2□No If Yes, Give Vietnam Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Municipal Government 12 Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Andrew Whetzel Ethel Trenum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Viola Whetzel/ wife 112 Walnut St, Westernport, Maryland 21562 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Removal from State 02/25/2011 View Cemetery Barton, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death ADSNOCA-RCINOMIA Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) 200 Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant ☐ Unknown Pregnant at time of death 5 Other (specify) Month the 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 23e. Did tobacco use contribute to the cause of death? Completed cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate performe death? 1 🗌 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 1 Yes 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and a jovestigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check on, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination Certifying Nurse Practioner: To the best of m only one) h occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number 1)0023371 02/31/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Dr. Qamar Zaman, 904 Seton Drive, Cumberland MD 31. Date filed (Month, Day, Year,

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State

Registrar

32 Registrar's Signature

FEB 2 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) February 02 PM **Physician** /Medical 4b. City, Town, or Location of Death Ac. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** timore The Johns Hopkins Hospital 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday **Funeral** Hours 1 M 2 X F 222-50-930 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City Town or Location 10b. be notified at 1 Yes 2 ☐ No Director 28a-f death with the 10g. Citizen of What Country? 10e Street and Number 5 720 23a Funeral items . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Yes 2 No 6 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ Dark 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation er than "natur the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other aumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Fatheti's Name (First, Middle, Last, Be 6 19a. Informa t's Name/Relationship (Type Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number of Print) item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Suburial permit. Pages
Department of i
Important: If itt
any injury or o
once. 2 Crem 3 K Removal from State Other (Specify) Donation 21. Sign neral Ser e Licensee 19805 TUNEYOU HOOME Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final CHRONIC MYE LOGENOUS LEUKEMIA WITH BLAST CRISIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy atten I for u Month Day Year in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4X Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Jas 2 No 1 Tyes 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 Tes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 2 Accident Injury 5 Pending investigation 1 🗌 Yes 2 🗌 No death. Director; A d in by the f 3 🗌 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) hours after within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

rit 31. Date filed (Month, Day, Year) FEB 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and or Location of Death **Examiner** 4b. City, Town, 4c. County of Death, Meritus Regional HAZELT LOWN Wastlingba Social Security Number 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours 1 X M 2 🗆 F (Month, Day, Year) 12/9/1969 WEST 234-21-7847 41 **Director** VIRGINIA Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified as 10a, State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WV MORGAN HEDGESVILLE 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 166 HOUSEHOLDER ROAD 25427 USA 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER COMMERCIAL Be 18. Mother's Name (First, Middle, Maiden Surname)
ELIZABETH LEE DEHAVEN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GARY E. WEIGLE, SR./DAD 200 N. LOUISIANA AVE., MARTINSBURG, WV 25401 Date 26, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗀 Donation 5 🗀 Other (Specify) MT. HOPE CEMETERY MARTINSBURG, WV 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ STOLE disease or condition Medical resulting in death) **Examiner** F. Is. Iblica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Be Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital မြ 1 🗌 Yes Other: 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mayner of Death 28a. Date of injury Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: At Investigation Suicide Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) MORTUS

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State Registrar 31. Date filed (Month, Day

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Robert Mitchell Wetzel February 5:45 AM M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 322 Redwood Avenue Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth ^{Year} 1941 1 ₹ M 2 □ F Months Days Hours Min. Aug. 15 216-38-0273 69 Director Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick 1X Yes 2 ☐ No Frederick MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 322 Redwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White f 1963 = 1965 Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fabricator Lumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur V. Wetzel Eva A. May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 <u>Shirley Wetzel</u> (Wife) Redwood Ave., Frederick, Maryland, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 2/18/2011 Smithsburg, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD MO1612 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malignant Bruchigens Carthona disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or). the attending physician and hed for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Arten Coroner 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? tension 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: ျှ 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 - Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 17, 2011 sun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ossumtown Pike MELISSA AS LINCION M. 31. Date_filed (Month, Day, Year) State Registrar ARIUR ZUIT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:00 PM Shirley Α. Young Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medica Plata Charle Conter _a 5. Social Security Number 8. Date of Birth (Month, Day, Year Aug. 25, 1 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min. Wash. **Director** 577-54-4963 68 1942 Usual Residence of Decedent 28a-f show 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Charles Pomfret 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8811 King George Court 20675 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 Yes If Yes, Giv 2 **X**No Baltimore, Maryland 21215-003 1 ☐ Yes 2 X No Specify. Completed 3 - Widowed 4 - Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Shirley Human Resource Personnel DC Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samuel permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. Mobley Rosa Byrd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8811 King George
Pomfret, MD 2067

20b. Place of Disposition (Name of cemetery, crematory or other place) Court Thomas Young Jr/husband 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 2/23/11 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aveyotropic Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence (*) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 4 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 140 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 46 1 🔲 Yes Certificate: To 1 Inpatient 2 FR/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number MU HO042445 February 17 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HICHAEL P!HEN T達し, りち POST OFFICE I-A WALDORF-MD20602 ROAD 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH RAISA ALTMARK 2011 06:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE ENVOY OF PIKESVILLE PIKESVILLE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country) BELARUS Days 1 🗆 M 2 😾 Months Hours Min. 217-53-5858 83 0470791928 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits **BALTIMORE** MD BALTIMORE 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 2 THIRD TEE COURT 21209 USA items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. the Medical Examiner Black, White, etc. ö þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify WHITE "natural", Completed 3 M Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PIANO TEACHER **EDUCATION** 4 event, Be 17. Father's Name (First, Middle, Last) Permit. Page 1 and 2 should be file Department of Health and Mental H Important If item 27 is marked any injury or act. 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN SOLOMON GOLDA FISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THIRD TEE COURT, BALTIMORE, MD 21209 ALIAKSANDR ALTMARK/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM 103/07/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final wh Onset and Death Ph sician/ disease or condition monte Medical resulting in death) to (or as a consequence of Examiner Sequentially list conditions, franciscus, cause. Enter Underlying Cause (Disease or linjury that initiated events Que to for as a consequence of: Exami resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No ed by the a 9 Unknown 9 Unknown Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 44 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check To the h within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 00043375

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 10:30 PM DAVID Ι ABRAMSON MARCH 07 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 3408 JANELLEN DRIVE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Country) 047067 1942 Director 68 NY 215-40-1036 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location the Maryland must be notified at by Funeral Director or 28a-f 1 Yes 2X No BALTIMORE BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3408 JANELLEN DRIVE 21208 USA and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Completed 3 Divorced WHITE Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING CERTIFIED PUBLIC ACCOUNTANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ SPECTOR RAUCHWERGER **ABRAHAM** LEAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRY ABRAMSON/WIFE 3408 JANELLEN DRIVE, BALTIMORE, MD Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cemetery, crematory or other place)
BETH YEHUDA ANSHE
KURLAND CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/09/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death
Unknown 5 Other (specify) g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law r 24 hours after death. Funeral Director: After this certificate has b certificate has the rector, page 2 s autopsy performed? Yes P 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 3 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred injury Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmove, mo 2123 401 n. Broadward Lauren Mauro 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1054 PM ASBURY MARCH Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE N/A **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - F Months Days Min. 236-86-5393 Director 0972071954 W. Country irginia 56 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Director 10d. Inside City Limits MD N/A 1X Yes 2 ☐ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3007 Mardel Ave. 21230 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Radio Dispatcher Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Hansel Dishman Joyce Immogean Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlie Harvey(husband) 3007 Mardel Ave., Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site crematory 03/08/11 Baltimore, MD 21. Signature of Funeral Service Licensee 305epHdH: OBYOwn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 amo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death a NON- ST ELEVATION MYOCARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** SEVERE SEPSIS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events MNKNOWN Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit certificate be executed PNEUMONIA <u>UNKNOWN</u> Due to (or as a consequence of): resulting in death) Last Physician/Medical RENAL CELL CANCER P.O. Box 68760 UNKNOWN IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy in 24 hours after death.

the Funeral Director: After this certificate Inpleted filled in by the funeral director, page performed? Yes 2 No death? 1 Tes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No မ 1 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 X Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No 2 Acciden Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe MD RES 001 MARCH 06. PV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 SOUTH HANDVER STREET TANYA MOROVATI

DHMH 17 Rev 7/2009

State Registrar HARBOR HOSPITAL

Year) 🛩

BALTIMORE, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month O 3 Year Jacqueline Austin 12:16 AM 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN N/A BALTIMORE HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign · Carolina 1 M 2 MF 0271871956 Director 220-64-9032 55 S. Usual Residence of Decedent or items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD N/A Baltimore Baltimore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 909 N. Central Ave. 21202 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Clerical PHHArval and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Willie Prescott Jr. Ruth Harry 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donel Austin(son) 909 N. Central Ave., Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Tremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory 03/09/11 Baltimore, MD 21. Signature of Funeral Service Licenses 230566Mdfff. Fown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Man 23a, Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician SEPSIS Medical resulting in death) Examiner ENDOCARDITIS BACTERIAL Sequentially list conditions Examiner Due to (or as a consequence or, If any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END STAGE RENAL DISEASE Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of FIBRILLATION 24a. Was an this certificate has page 2 autopsy death? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 2 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 24 hours after death Funeral Director: Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 MT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLYD, BALTIMORE, CAROLINE D'SOUZA MD 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O.3 nge Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore IMORE 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 **X** M 2 □ F Country) **Director** Yrs show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho many injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ms 23a or 28a-f short must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ■ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Never Married 2 ☐ Married by 1 ☐ Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Seconday (0-12) College (1-4 or 5+ NIA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ ames 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route 962 James Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause in each line. Approximate erval Between Immediate Cause (Final Physician/ TIC disease or condition Medical resulting in death) Due to (or as a conseque e of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Ut derping Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be en 124 hours after death. I set hours after death. Penneral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 🗌 Yes 2 🔂 🔾 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 2 No 1 Tes Other: DEPice ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 100 Natural 5 Pending work' 2 Accident
3 Suicide 2 \square No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur ٥ 29d. Date signed (Month, Day, Year) 1004537-5

State Registrar Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 07454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Rosebud Burkhart :201AM 2011 larc /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Couto MSVI Himore harlestown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth 12/26/1919 9. Birthplace (State or Foreign **Funeral** 91 Days Hours 1 ☐ M 2X F 217-05-6485 Director Yrs. Virginia Usual Residence of Decedent the Maryland ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Heelth and Mental Hygiene.
If item 27 is marked other then "naturel", or iteme 23a or 28a-1 show or other traumatic event. The Madical Examina 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore Catonsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, RG 115S 21228 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Welford Shelhoss Princess Euhalie Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Yarnell, Daughter 343 River Road, Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any njury or oti once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ← ☐ Denation 5 ☐ Other (Specify) Lorraine Park Cem. 3/29/2011 Woodlawn, Maryland 2 Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -roke disease or condition dav resulting in death) /Medical Due to (or as a consequence of): Examiner THEN MONIA Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury as a consequence of): Examine The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Ho Month Day Year 4□Pregnant at time of death 5 \(\text{Other (specify)} \) Records, P.O. 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificete has autopsy performed Division of Vital 1□ Yes 21/10 the Hospital or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death Check only one 1 Yes 2 No Other: 4 Thursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th 27. Manner of Beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending after death.

Director: Aft
J in by the fun 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 47009 Name and address of person who completed suse of death (Item 23a) (Type, Print) hoice Lane Baltimore, MD 21228 Maiden

Registrar

31. Date filed (Mo

nth, Day, Year

MAR 10

32. Fedistrar's Signature

				epartment of Health and	Mental Hygie	ne
				Certificate of Death	Reg.	No.2011 07155
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) Cyric Boule		2. Date of Death	7 289/ 3. Time of Death
444	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In vrs. last hirthdox	Randallstown		Baltimore Co.
	Funeral Director		5. Social Security Number $216-12-5245$ 1^{7} . Age (In yrs. last birthdom) $216-12-5245$ 1^{7} . Age (In yrs. last birthdom) 1^{7} .	Months Days Hours Min	8. Date of Birth (Month, Day, Yes) 09/24/192	9. Birthplace (State or Foreign Country) MD
	*		Usual Residence of Decedent		109/24/192	-2 110
	yland •f shc ed at	햟	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	e Maı r 28a notifi	Director	MD Anne Arundel Co. Glen 1			1 ☐ Yes 2 ☐ No
	vith th		1006 Phillip Drive	10f. Zip Code 21061	10g.	Citizen of What Country?
	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? (Sp. 1997)	pecify Yes or No-	United States 14. Race - American Indian,
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1☒ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🖾 No Specify:		Black, White, etc. Specify: White
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Nar	shour and 7 is m			ailing Address (Street and Number or Ru		
e,	and 2 Health em 2 ther 1			06 Phillip Drive	Glen Burn	
nor	Page 1 ment of ant: If ii ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, of	rrematory or other place)		c. Location - City or Town, State
Baltimore,	permit. P Departm Importar any injur		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	ven Mem. Park 103/1		len Burnie, Maryland
ä	Depar Depar Impor any ir		M01121	Services PA; 1 2nd	Ave SW; G	len Burnie, MD 21061
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
3	hysician/	0. 0	Immediate Cause (Final disease or condition MRL) 6NA/	IT MESUT	zeloun	
	Medical Examiner		resulting in death) a. Due to (or as a consequence of):			
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	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury			
	exectian an irial-tr	EX	that initiated events c. Due to (or as a consequence of):			
09	cate be executed physician and s the burial-transit	edical I	d			
687	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent prograpt 23c. If yes, outcome of pregnancy			
Rox	sician: The law requires that the death certific certificate has been signed by the attending trector, page 2 should be detached for use as	Physician/M	in the past 12 months?	G ☐ Ectopic pregnancy G ☐ Other (specify)		23d. Date of delivery Month Day Year
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ŏ	law re nas be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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Vital	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I I I I	26. Place of Death (Chec	k only one)	1006.600
010	g Physer this eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time	tient 3 🗆 DOA 📗 4 🗀 Nursing H	ome 5 Residence 28d. Describe how in	
000	anding ath. r: Afte ne fun	icat	↑ Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ AccidentInvestigation	/ work? M 1 ☐ Yes 2 ☐ No	200. 20001120 11011 111	july obsulted
DIVISION	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
5	pital ours a ours a erai D		29a. Certifier Certifying Physician: To the best of my knowledge, dear			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dear only one) Medical Examiner: On the basis of examination and/or involved only one) Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred a	t the time, date and pla	ace, and due to the cause(s) and manner stated.
	To the state of th		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	iv		Joels Don	10/38/	2 M	rch8, 2011
(7"		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Saxin Blue	100	rch8, 2011
	Stat		31. Date filed (Month, Day, Year) 62. Registrar's Signature	SAAM SLV	JUNK	" H 2/06/
	Registra	_	MAR 1 0 2011 Denna B. 190	are		

			1 _ State	partment of Health and N	Mental Hygi	ene	071 - 6
	-		Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Re 2. Date of Death	g. No./	3. Time of Death
	Physicia Medic		SIDNEY BERMA	N	Mara		103cpM
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
_	Formul		3410 ASSOCIATED WAY, #410 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)	OWINGS MILLS If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTI	
	Funeral Director		5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) $214-12-1431$ 88 Yrs.	Months Days Hours Min.	07/28/1	(ear) Count	lace (State or Foreign MD
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	arylan a-f sh ified a	Director	, , , , , , , , , , , , , , , , , , , ,	IGS MILLS		"	1 Yes 2xtx No
	the M or 28		10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Coun	
	n with	Funeral	3410 ASSOCIATED WAY, #410	21117		USA	
	r item		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	· ·
036	filed within 72 hours after death with the Maryland al Hygiene. Jother than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🛣 Married 1 🛣 Yes 2 ☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🎇 No Specify:			IITE
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alti:	permit. Page Department Important: I any injury o					BALTIMORE,	
m	9 9 E 6	ŀ	Michael Suger	8900 REISTERSTOWN			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arres	t,	Approximate Interval Between
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× 687	h certi tendin r use a	lan/I	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnancy		23d. Date of delive	*
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P.O.	that the ned by the detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
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o to	g Phy er this neral d	te: To	27. Manner of Death 28a. Date of injury 28b. Time of	of 28c. Injury at	me 5 X Residen 28d. Describe how	ce 6 Other (Specify) injury occurred	
on	tendin eath. or: Aft the fur	Certificate:	1 Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	work? M 1 ☐ Yes 2 ☐ No			
Division of	or Att after d Direct in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Attending Physiciam: within 24 hours after death To the Funeral Director. After this certifica completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occured at the time, date and place, an	d due to the cause	e(s) and manner as stated	d.
	the Ho nin 24 the Fu	Mec	(Check 2 ← Medical Examiner: On the basis of examination and/or inve only one) 3 ☐ Certifying Nurse Practioner: To the best of my knowledge.	stigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and e, and due to the ca	place, and due to the cau ause(s) and manner as sta	se(s) and manner stated. ited.
	viti Cor		29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, D	ay, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	5	VIA oh 8,	2011
	10		Marc in BCB 6934 An	Print) DISE To	Sn, L	NZ	1061
	Stat Registra	_	31. Date filed (Month, Day, Year) MAR 1 0 2011	Kel	,		
			HILL - A PALL MONDON		_		

			For State Registrar	State of Mai		partment of He e <i>rtificate of De</i>			20	11 07457
	Physicia	an/	1. Decedent's Name (First, Middle, La	•		nundate of Be	<i>-</i>	2. Date of De		3. Time of Death
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Medi Examir	cal	DAVID 4a. Facility Name (if not institution, give		SR.	4b, City, Town, or Lo	ocation of Death	Marci	h 3/ 22	(ear, 1953 M
Specie	LAGIIII		maryland Gre	neral Ho:	spital	Baltimor	re Cr	fy	4c. County of N/A	
1	Funeral Director		5. Social Security Number 6. S 247-32-1700 Usual Residence of Decedent	Sex 7. Age (In yrs. last birthday 85 Yrs.		f Under 24 Hrs. Hours Min.	8. Pate of Birl (Month, Da MAY 26		9. Birthplace (State or Foreign Country) SOUTH CAROLINA
	land show dat	호	10a. State 10b. County	1	10c. City, Town or L	ocation				10d. Inside City Limits
	e Mary r 28a-i notifie	Sirec	MARYLAND N/A		В	ALTIMORE				1X□ Yes 2□ No
	tth with the Maryland ms 23a or 28a-f sho must be notified at	Funeral Director	727 DRUID PARK I.	AKE DR AF	т 9к	10f. Zip Code 2121	17		10g. Citizen of Wh	•
) 98	er dea or ite niner	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 142 Yes 2 \(\square\) No	er in U.S. 13	. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
21215-0036	hours and rate ical Ex	Completed	3 XXWidowed 4 ☐ Divorced 15. Decedent's B	Year or Dates. 43		edent's Usual Occupation			Specify: I	
1215	within 72 giene. Ier than "r the Med	omp	(Specify only highest gi Elementary/Seconday (0-12)	ade completed) College (1-4 or 5+)	(Give	e kind of work done durii DO NOT use retired)	ing most of work	ng		
	filed witl al Hygier d other i	Be C	3rd grade 17. Father's Name (First, Middle, Last)		MA	SON BRICKLA		e (First Middle	Maiden Surname)	TRUCTION
ylan	d be fil Mental arked atic ev	욘	FLOYD JONES					INE BUT		
۷ar	should h and Mu 7 is mar traumati	13	19a. Informant's Name/Relationship (114	ling Address (Street and			-	
e,	f Healt item 2 other		Sheila Gilliam/Da 20a. Method of Disposition		20b. Place of Disp	Queensberr		Baltim Date	ore, Md.,	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa once.		1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State		ematory or other place) N CEMETERY	03-1			, MARYLAND
Ball	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra	7	21. Si in whe of Fund all Service given	ee	4	22. Name and Address of WILLIAM C B 1206 W NORT	of Facility ROWN CO TH AVENU	MMUNITY E	FUNERAL	HOME P.A.
			23d. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final	plications that caused the cause on each line.	ne death. Do not en	ter the mode of dying, s	such as cardiac o	r respiratory arr	rest,	Approximate Interval Between Onset and Death
pale	Physician/ Medical		disease or condition resulting in death)	a. Ventrue Due to (or as a c	CU(AR	FibRillo	Mon	,		Onset and Death
	Examiner	J.	Sequentially list conditions,	b. Corona	ary AK	tery D	islas	e		
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a c	ons suence of);	iver 2	Vistas	e.		
	cate be executed physician and the burial-transit	I Exa	that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	, 0.				
200	physic the bu	edical	•	d _q						
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 ☐ Pregnant at til 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date o	
s, P.O.	ires that th signed by d be detac	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause given i	in Part I.			ute to the cause of death?
Records,	iw requisits been 2 should	Completed			· ·			24a. Was a	an 24b. Wer	re autopsy findings available
Rec	sician: The la certificate ha irector, page 2	Com						autop perfor 1 Yes	rmed? / dea	or to completion of cause of tth? Yes 2 No
/ital	sician s certifi lirector	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	0 7 50 0 1 11	_ Other:	of Death (Check			
Division of Vital	nding Phy ath. r: After this e funeral d	Certificate: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Y	2 ER/Outpatie 28b. Time of injury	of 28c. Injury at work?			lence 6 Other (5 ow injury occurred	Specify)
Division	tal or Atters after des al Directored in by the	I Certif	3 Suicide 6 Could not be determined		- At home, farm, st Specify)	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	the Hospi nin 24 hou the Funer npleted fill	Medical	(Check 2 Medical Exam only one) 3 Certifying Nurs	sician: To the best of my iner: On the basis of exan se Practioner: To the bes	nination and/or inve	stigation, in my opinion, d	death occurred at	the time, date ar	nd place, and due to	the cause(s) and manner stated.
	P 1 2 00		29b. Signature and title of certifier Robins R	one. MD	9	29c. License nur			29d. Date signed (<i>N</i>	Ipnth, Day, Year)
	HV		30: Name and address of person who of the Duna Ka	na, m	210.9	Print) Mary	land c	Simera	3/7/ al Hos,	prtal
	Stat Registra	c	31. Date filed (Month, Day, Year) MAR 1 0 2011	32. Registrar's	Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Bernadine L Colle 23:17 p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Elizabeth Rehab. & Nursing Center Halethorpe Baltimore 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 DF Months Days Min. Hours Director 2/08/1926 Maryland 85 216**-**20-4490 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2X No Anne Arundel Co. Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6213 Chestnut Oak Lane 21090 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Proof Reader Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ James Faby Louise Strumpeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) _Jerome Colley 6213 Chestnut Oak Lane Linthicum, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 3/14/2011 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, encepholopath. heranc disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Uro Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the a d be detached fo Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown CHF 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed? Yes 2 2 No C 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No ၉ Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No s after death Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number 124 hours a e Funeral € Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12111015 cap 319/11

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5010

R 10

Sboro

3320

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 Year March 11:01 P M Kenneth Elbert Caldwell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign ^{Year)} 1949 220-52-6361 July 29 Director Maryland Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💆 No Harford Aberdeen MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 355 S. Deen Avenue 21001 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1969 Black, White, etc b 1 Never Married 2 Married Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 1971 3 XWidowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elbert Neal Caldwell Kathleen Stalya Pennington permit. Page 1 and 2 should i Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 71 Willard Dr; North East, Maryland 21914 Alice Krauss - sister any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, scheart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a Exam the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 'ER IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year q Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 🗌 Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🗌 No Certificate: To 1 Yes 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide Investigation М 1 Tes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and tiple of certifier D35832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH STREET, SUITE C, ELKTON, MD 21921 ARMA MD 31. Date filed (Month, Day, Year) 32. Registrare Signat

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7;00P 2. Date of Death Physician/ Rose Cross March 201 Ta Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 906 Meadow Ridge Court Bel Air Harford . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 217-26-3995 1 □ M 2 🛛 F Director Vrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 906 Meadow Ridge Court 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: 3 ☒ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stephen Turkin Veronica Belinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica K. Walsh-Woods/Daughtet 906 Meadow Ridge Court, Bel Air, Maryland 21014 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Parkwood Cemetery 3-10-11 |Baltimore,Maryland CANBY 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Fulleral Service Linensee Jes En in 4. 6009Harford Road, Baltimore, Maryland 21214 000 Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final Onset and Death Physician/ De to (or as a consequence of) disease or condition i week Medical resulting in death) **Examiner** nhacia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Demonta YEARS Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month ☐ Pregnant at time of death ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by myas thenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of (40 24a. Was an Jas autopsy page performed? death? Chronic anemia 2 -N 1 Yes Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural $5 \square$ Pending work? injury 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar OHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1Clues2

Wend

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

1) 3/295

Baltimore

mo 2/206

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ illie Month O.3 MAE DAVIS 2011 12:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2616 BERYL AVENUE BALTIMORE 8. Date of Birth
(Month, Day, Year)
01-01-1918 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F 213-26-2054 93 Yrs. **Director** GA Usual Residence of Decedent 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director MDBALTIMORE 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2616 BERYL AVENUE 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANo Specify: 3 ₩ Widowed 4 □ Divorced Specify: BLACK Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE DOMESTIC TECH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BILLINGS VIOLA THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodfolk 2616 BERYL AVE. BALTIMORE, MO. 21205 / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State 3/15/11 CROWNSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCKS 21. Signatur of Funeral Service Licensee 4905 YORK ROAD. BAUTO, MO155 MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Pnysician/ Medical resulting in death) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live Birth 2 ☐ Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by esophas 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕦 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation within 24 hours after death

To the Funeral Director:,

completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) 21218 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mont 3. Time of Death Physician/ els 1:0 <u>10</u> S Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death URNI 8. Date of Birth last birthday **Funeral** 9. Birthplace (State or Foreign 1 M 2 Min Director Yrs 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ms 23a or 28a-f sho must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No timore 10f. Zip Code 10g. Citizen of What Country? Funeral aston 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Armed Forces?
1 ☐ Yes 2 ☐ No is marked other than "natural", or ite aumatic event, the Medical Examiner Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced Completed ac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working fe. DO NOT use retired ofdy (0-12) College (1-4 or 5+) pnaon Be 17. Father's Name (First, Middle, Last) ပ္ 10W1 or Rural Route Number, City or Town, State, Zip Code) 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) imore. 21. Signature of Funeral Service Licensee Services OB 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MUDCARDIOI disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine MEMOSCI CAMDIO MASCULAR DISCASE GROTIC Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi attending physician and Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? should be detached for Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death' 24 hours after death.

Funeral Director: After this certificate Yes Yes To Be Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Division of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tyes 2 🗆 No Investigation completed filled in by the Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination allows investigation, in my spanish, decay to the cause (s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b, Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 GATEWAY DRIVE SUIZ6

Registrar

State

Box 68760. P.O. Division or Vital Records,

Registrar

FANELLI 31. Date filed (Month, Day, Year) MAR 1 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3001 SOUTH HANOVER STREET BALTIMORE, MARYLAND 21225

MARCH, OZ,

RES-001

11-01792
Steffany Foley

teffany Foley		State 1- For State Registrar	of Maryland / I		ent of Health a ate of Death	nd Mental	-	2011 g. No.	07465
Physici Medical Exam		1. Decedent's Name (First, Middle,Las					2. Date of Deat Month	h Day Year	3. Time of Death 2018 hrs
eculcai Exam	illei	Steffany 4a. Facility Name (if not institution, give	Foley street and number)		4b. City, Town,	or Location of D	March 5, 2	4c. County of Death	
		Baltimore Washington Me	dical Center		Glen Burir	ne		Anne Arundel	
Funeral Director			7. Age (M 2XF	In yrs. last birth	Months Day		Min.	h(MM/DD/YYYY) 9. Bird Foreig L, 1953	
nay.		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town o	or Location				10d. Inside City Limits
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Maryland 28a-f show d at once,	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once,		1503 Tieman Driv				21061		United St	
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev	,	 Was Decedent of H If Yes, specify Cub 			White, etc.	can Indian, Black,
after d al", or	by Fu	3 Widowed 4 Divorced	1 Yes 2 X If Yes, Give Year or Dates:	No	1 Yes 2 X	lo specify:		Specify: Wh	ite
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	ted t	15. Decedent's Education (Specify or Elementary/Secondary (0-12)		d	ecedent's Usual Occup uring most of working li			16b. Kind of Business/I	ndustry
)36 thin 72 te. than '	Completed	12	College (1-4 or 5+)		Contract	or		Westing	house
5-0(led wi Hygier other		17. Father's Name (First, Middle, Last)				18.Mother's Na	ame (First, Middle, M		
21215-0036 21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	Laurence E 19a. Informant's Name/Relationship (T)	roley	110h	Mailing Address (St.		Dailey	ber, City or Town, State	Zin Code)
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re, r 1 and f Healt f item er trac		20a. Method of Disposition 1 Burial 2 X Cremation 3		20b, Place of	Disposition (Name of c	emetery,	Date	20c. Location - City or	
Baltimore, MD oemit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumati		4 Donation 5 Other Specify:			ic Cremato	ry	larch 9, 2011	Glen Burn	ie, MD
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	Ш	21. Signature of Funeral Service Licen		MO1121	22. Name and Addre		Singleton	Funeral &	Cremation
Physician		23a. Part I. Enter the disease, or comp						Glen Burn: st, shock, or heart	Approximate Interval
/Medical Examiner	Ш	failure. List only one cause on ea Immediate Cause (Final disease a	Cardiac A	Arrhyth	mia				Between Onset and Death
2.0		or condition resulting in death)	Due to (or as a consequ	ience of):					
	힏		Oue to (or as a consequ	ence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
ecuted and transit	Ē	d							
f 0, e be executed ysician and burial - transit	edical	X UNPENDED	AMENDED 23a,	27 per	me g913 3-	·16–11 v	t		
Sox 6876 leath certificate e attending phy for use as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	of pregnancy 2	Fetal death 3	Ectopic pre	gnancy	23d. Date of delivery Month D	ay Year
OX 6 eath cer attend for use	Physician/N	1 Yes 2 No 9 ✔ Unknown	4 Pregnant at tim	e of death 5	Other (Specify)				
O. B. at the de lby the		Part II. Other significant conditions	contributing to death be	ut not resulting	in the underlying cause	given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
ires that signed be dete	d b						1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
ords w requ	plete						24a. Was a autops	y prior to c	opsy findings available ompletion of cause of
tal Records, cian: The law require certificate has been si ector, page 2 should b	Completed						perform 1 Yes 2		s 2 No
Vital Reconstitute The larthis certificate had director, page 2	a	25. Was case referred to medical examiner?	ospital: 1 Inpatient	2 🗸 ER/Out		Other		Residence 6 Other	
ing Physical directal	읽	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Ti		ury at Work?		ow injury occurred	·
ion tendin tor: A	aţio	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		1	Yes 2 No			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury	r - At home, far	m, street, factory, office	building, etc.	28f. Location (St or Town, Sta	treet and Number or Rur ate)	ral Route Number, City
o the Hos	Medical (one) 2 Medical Examiner:						o(s) and manner as state and place, and due to the	
	ž	29b. Signature and title of certifier	. 1	11	,	ise number		29d. Date signed (Mon	th, Day, Year)
6			NI. /	//	0.0	.M.E.		March 6, 2011	
100		 Name and address of person whole Jack Titus MD. Deputy C 	ompleted cause of ceat Chief Medical Exa) W. Baltimore St	reet, Baltimo	re, MD 21223		
		31. Date filed (Month, Day, Year)	32. R distants	Signature					
Regist		MAR 1 U 20	Chances	1 10.	Marked .				
DHMH 17 Rev 1/20	<i>)</i> U1			ORI	GINAL			OCME	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Feinsod MARCH MurieL 2011 01:00A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **BALTIMORE** SUNRISE OF PIKESVILLE PIKESVILLE Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Months Days 1 🗆 M 2 👿 F Hours 156-01-6158 89 12 7 7 7 7 7 12 1 Vrs Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD BALTIMORE 1 Yes XX No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral with USA 7523 STREAM CROSSING ROAD 21209 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE Specify: 3 🕅 Widowed 4 🗆 Divorced er than "natur , the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) BANK COUNSELOR FINANCE is marked other aumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental t. Page 1 and 2 should be fi tment of Health and Menta rtant: If item 27 is marked jury or other traumatic ev ပ **JACOB** WEINER LILLIAN ZEIDBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7523 STREAM CROSSING ROAD, BALTIMORE, MD 21209 JOSEPH FEINSOD/SON permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) MWOOD CEMETERY 03/08/2011 NEW BRUNSWICK.NJ 21. Signature o Funeral Service U 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardina acces disease or condition Medical resulting in death) Due to (or as a consequence of Examiner anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit e o Keme Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2.3 2 No 1 Yes Yes To the Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 459 15/4C Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accider ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at Dentifying Number Practice on To the best of my knowledge, scattered at the time. Sale and place, and sue to the cause(s) and memories estated (Check 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 1611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere An #504 BOLTO MOLIZE 6we 11 U 1 31. Date filed (Month, Day, Registrar's Signature State MAR 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 07467 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 LARRY FORD 11:00 a^M Medical March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 444 WALTON COURT N/A BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Sex XIX M 2 □ F 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days Hours Month, Day, Feb. 17 Year) 1954 Director Yrs Country) MARYLAND 218-58-7527 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No MARYLAND N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 444 WALTON COURT 21201 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) llth grade DISABLED N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any Injury or other traumatic. once. JOHN FORD other traumatic LOUISE SANDERS FORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tori Ford/Daughter .454 Clairidge Rd., Baltimore, Md., 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Domation 5 Other (Specify) METRO CREMATORY 03-10-2011 BALTIMORE, MARYLAND 21. Signature of Funeral Service Coense WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Nac Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner is cheric Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Nm 11 attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death Month Day Year 1 Yes 2 g Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate har funeral director, page. performed? Yes 2 death? 2 4 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 P No Other: မှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death
To the Funeral Director; / Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Hours, ms) 1002290 3/3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ien ne

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

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32. Registrar's Signature

HAY BS

			Please	Type or Print in					_	•	
		-	For State	State of Marylan	•		nt of Health and te of Death	Mental Hygi	ene 2011	071.68	
			Registrar 1. Decadent's Name (First, Middle, Las	t) 0 00	Cer	unca	e or Dearn	2. Date of Death	g. No UII	3. Time of Death	
Phys M	siciar edica		Dora Lee	Grittin				March	8, 2011	0419 M	
Exa	ımine	er 4a facility Name (if not institution, give street and number)					Flown, or Location of Death	4c. County of Dea	4c. County of Death Bathimores		
Fune Direc	_		5. Social Security Number 6. Se 346-42-7032	ех П м 2 (X F) 7. Age (In yrs I	ast birthday) Yrs.	If Unde Months	er 1 Year If Under 24 Hrs Days Hours Min.	8. Date of Birth	9. Bir	rthplace (State or Foreign ountry)	
bne	ă	ě	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10d. Inside City Limits	
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15-0036 72 hours after death with the Maryland in "natural", or items 23a or 28a-f should be recitived by	inast per	Funeral L	5218 Fredcres	t Road		10f. Zi	21229	10	og. Citizen of What Co	A '	
or item		by Fui	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No	S. 13. V	Vas Dece Yes, sp€	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit		
21215-0036 within 72 hours after giene. ner than "natural", o	al EXall	ted	3 ₩Widowed 4 □ Divorced	If Yes, Give Year or Dates.			2 No Specify:		Specify: ${\mathcal B}$	lack	
215- n 72 hc e.	Medical Property of the Proper	Completed	15. Decedent's Ed (Specify only highest gra Elementary Seponday (0-12)		(Give k		ial Occupation ork done during most of wor e retir a d)	rking 1	6b. Kind of Business	1	
d 212 ed within Hygiene. other than	1, 11	Be C	/th		1	bm	estic		Domes	stic	
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth		10 B	17. Father's Name (First, Middle, Last) Henry Carson	Williams		<u>_</u>	18. Ngher's Nar	ne First, Middle, Ma	aiden Surname)		
	n denii		19a. Informan 's Name/Relationship (Ty Lillie Addi Sor		19b. Mailin	a Addres	s (Street and Number or Ru	ral Route Number, C Balto	-	ip Code) 21229	
0 - 0 - 1	5 I		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	Removal from State 20b. P	lace of Dispos emetery, crem			Date 2	Oc. Location - City or Baltino	Town, State	
Baltimo	once.	ł	21. Sig at the of Funeral Service License		MOOY 22.	Vace	Aldress Cacilit	ene fun	wal Ser	vices	
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. → Ph_sicia	an/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.	i. Do not ente	i the mot	ie or dyring, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death	
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Division o To the Hospital or Attending I within 24 hours after death To the Funeral Director: After completed filled in by the funer	. Spell	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination Practioner: To the best of my	and/or investig	gation, in	my opinion, death occurred a	at the time, date and	place, and due to the	cause(s) and manner stated.	
To the Committee			29b. Signature and title of certifier	10.0			c. License number		d. Date signed (Monti	h, Day, Year)	
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7)		30. Name and address of person who co	6701 N. Cha	Les St	t- S.	uite 4105,	Baltin	Love, M	021204	
	State strar		31. Date filed (Month, Day, Year) MAR 102	32. Rigistrar's Signate	ure .	arks	<i>)</i> .	119			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** A M Jeanette Guerrieri March 1100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Combridge
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F Months Days Hours Min. 218-03-2475 90 **Director** Nov 1920 6 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinant results at the modified at 1 ☐ Yes 💥 ☐ No Director Maryland Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29620 Porpoise Creek Road 21673 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes My No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify δ, Specify: 3 Widowed 4 ☐ Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Tailor Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pietro Armenio Giovanni Rifici 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Guerrieri / Son 2906 Anderson Rd. White Hall MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March^{Date} 11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5XOther (Specify) entombment Lorraine Park 2011 Woodlawn, MD 22. Name and Address of Facility Singleton Funeral & Cremation has Services PA 1 2nd Ave SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscientiz Cordinoscular discou Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner money if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Day Year 5 Other (specify) P.0. the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 autopsy performed 1 □Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

le Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047924

Registrar

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31. Date filed (Month, Day,

Secnette

JURE FIRE

CATBRIDGE MD 216/3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

503

32. Registrar's Signature

THANKY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OLDHIZSCH Julius Goldhirsh 0921 TARCH 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death n/a Manland Sex U INIVERSITY OF Medical If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 6. Sex. **U**1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday, Country) PA Days 1676271935 Director 173-26-7787 75 Yrs. Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 🔀 No HOWARD MD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a Examiner must be Funeral 6277 BRANCH BEECH 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) ELECTRICAL ENGINEER RESEARCH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **ISADORE** GOLDHIRSH RACHEL GROSSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH GOLDHIRSH / WIFE 6277 BRANCH BEECH, COLUMBIA, MD 21044 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) COLUMBIA, MD COLUMBIA MEMORIAL PARK 03/08/2011 . Signature of Funeral Service Liter ee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, DIFFOUE disease or condition resulting in death) ALVEDIGR Medical Due to (or as a consequence of) Examiner inromocy spenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed (eokemia M76/0/10109471C attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEMORRHAGIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? preumonia 24a. Was an autopsy performed To the Funeral Director: After this certificate completed filled in by the funeral director, pag 2 🗆 No 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direct City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0069556 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, LIBWYGSACTMORE 20201 SWITH GRECHE 170 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

11-01120 Tammie Doreen	Gor	Please Type or Print in Black Indelible zalez State of Maryland / Department			egible.						
		- For State Certificate			Reg. No. 2011	07471					
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Tammie Doreen Gonzalez			Day Year y 9, 2011	3. Time of Death 1250 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death Oakland Garrett									
Funeral Director		5. Social Security Numbetunk 6. Sex 1. Age (In yrs. last birthday) 1. Months Days Hours Min. Feb 24, 1972 Foreign Cour									
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5-0036 iled within 7 Hygiene. Inther than		17. Father's Name (First, Middle, Last) unk	18.Moth	er's Name (First, Middle	e, Maiden Surname)						
2121 nuld be fi Mental marked	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and No	ncetta Lugr		e, Zip Code)					
MD d 2 sho lith and n 27 is		Michael Gonzalez - stepfather 94	3 Bakewell Ct	; Lake Mary	y, FL 32746						
MOTE, Pages I an nent of Hea nut: If ite		1 Burial 2 Cremation 3 Removal from State crematory or	oosition (Name of cemetery, other place)	Date	20c. Location - City or	Town, State					
Baltim permit. Pa Departmen Important injury or or	ł	4 Donation 5 Houser Specify: in State 21. Si nature of Funeral Service Licensee 2. Wanter Director 2.	2. Name and Address of Facil	 ^{lity} State Ana	atomy Board						
m ឧក្សន	1	23a. Part Enter the disease, or complications that caused the death. Do not enter	655 W. Balti			21201 Approximate Interval					
/Medical		failure List only one cause on each line. Immediate Cause (Final disease a Narcotic (Fentanyl and Morphine		odial of Toophatory o	arroot, or room	Between Onset and Death					
		or condition resulting in death) Due to (or as a consequence of):	Due to (or as a consequence of): b								
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Division of Vital Records, tal or Attending Physician: The law require is after death. Tal Director: After this certificate has been sided in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Completed			per	formed? prior to death? s 2 No 1 Ve	completion of cause of					
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Divisipital or At ours after d filled in by	Sertif	3 Suicide 6 ✓ Could not be determined (Specify) Hotel/Motel	rect, ractory, office ballating,	or Town							
	ledical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or one) 2 W Medical Examiner: On the basis of examination and/or invest									
Ta wit To COM	ĕ	and manner stated. 29b. Signature and title of certifier	29c. License numbe	er	29d. Date signed (Mo.	nth, Day, Year)					
		Clubs	O.C.M.E.		February 10, 201	11					
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. B	altimore Street, Baltim	nore, MD 21223							
Sta Registi	-	31. Date filed (Month, Day, Year) NAR 1 0 2011 MAR 2011	W								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 145 AM Maryan 201 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death Baltimore 8. Date of Birth ge (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 1 M 2 Min **Director** 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked outher than "natural", or items 23a or 28a-f sho all propriate items in the medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21206 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetolog Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Rolete Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Vear Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy , page death? this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural iniury work? 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memoria State Registrar

Baltimore, Maryland 21215-0036

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 06 P^{M} HERSON 2011 5:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F Hours Min. Months 10/28/1918 92 **Director** 476-18-6782 Usual Residence of Decedent show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 ☐ Yes 2XI No MD BALTIMORE RANDALLSTOWN 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral 8711 ALLENSWOOD ROAD USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 KWidowed 4 Divorced Specify. WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than NER ISRAEL life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) SECRETARY RABINICAL COLLEGE is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **ABRAHAM** FRIEDMAN **JENNY** ZIEVE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE ZIMMERMAN/DAUGHTER 8711 ALLENSWOOD ROAD, RANDALLSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1:
Department of I
Important: If it
any injury or of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) WHALEY STREET CEM. 03/07/2011 COLUMBIA, SC 21. Signature of Funeral Service Licen-22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each vine. Approximate Interval Between Onset and De t Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 ☐ Yes 2 ☐ No 2 X No **Division of Vital** I or Attending Physician: after death. Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Investigation Could not be completed filled in by the 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KATEN W. METULITY W.) 2835 Smm th

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	ertific	ate of	Death				R€	g. No.		
Physici Indical Exami		Decedent's Name (First, Middle	Raymond Andrew Hall Month March 4, 2011								3. Time of Death 0840 hrs			
		4a. Facility Name (if not institution Harbor Hospital Center		41	o. City, Tov Baltimo		ocation of	Death	4c. Coun		of Death			
Funeral Director		5. Social Security Number 217 52 8421	6. Sex	7. Age (In yrs 62	. last birt	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.		6/1949	Foreig	thplace (State or in untry) Mary land
v any		Usual Residence of Decedent 10a. State 10b. County		10c. Cit		or Locatio								10d. Inside City Limits
and sho	ō		e Arundel		Bal	ltimo	re							1 Yes 2 No
the Maryl	Director	10e. Street and Number 413 Church St	creet		<u>.</u>		10f. Zip Co	ode 2122	25		10	og. Citizen of V	/hat Cour	
Baltimore, MD 21215-0036 Departit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Stalent and Mental Hygievier. In the Maryland Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 MM	Armed F	2 X No	U.S.	If Ye	s, specify (uban, I	Mexican, F	n? (Spe Puerto R	cify Yes or No- ican, etc.)		te, etc.	can Indian, Black,
after iner	by		orced If Yes, Giva Ye or Dates:				res 2 X					Specify.	WI	nite
hours	pe	15. Decedent's Education (Spec					s Usual Oc st of working					16b. Kind of B	usiness/l	ndustry
0036 within 72 iene. er than "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		Med	chani						t Me	tal
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle,	Raymon	nd Hall	1					Mild	lred Ch			
MD 2 d 2 should lth and M n 27 is m	7	19a. Informant's Name/Relations Mary Hall / V					Address (nurch			er or Ru		ber, City or To		
and 2 sealth tem 2 traum	177	20a. Method of Disposition	ATTE	20b			on (Name			-	Date	20c. Location		and 21225 Town, State
Ges 1 t of H		1 ABurial 2 Cremation	3 Removal fi	rom State	cremate	ory or othe				02/0	00/2011			
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Donation 5 Other Sp 21. Signature of Funeral Service			suai				·				-	Maryland
Depart		21. Signature of Funeral Service Ucensee 22. Name and Address of Facility Gonce Funeral Service, F 4001 Ritchie Highway Baltimore, Marylan										land 21225		
Physician		23a. Part I. Enter the disease, or failure. List only one cause		ed the deat	h. Do no	_ 1				-	-		_	Approximate Interval Between Onset and
/Medical _xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Ather	cosclero		Card	liovas	scu1	ar D	isea	se			Death
		Sequentially list conditions,	b	consequence	OI).									
	iner	if any, leading to immediate Due to (or as a consequence of):												
=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):									
3760, ficate be executed g physician and s the burial - transit			1 d	00 0	,		01/	, ,	0 11					
a a a	n/Medical	X UNPENDED	AMENDED	23a,27		r me	g914	4-2	22-11	Vt				
	Ž	IF FEMALE: 23b. Was decedent pregnant in th		outcome of pre pirth		Feta	death	3	Ectopic p	regnand	:y	23d. Date of Month		ay Year
Box 687 e death certifithe attending 1 ed for use as t	Physicia	past 12 months?	4 Pregr	nant at time of d			r (Specify					1		33
the degraph of the de	Phy	Part II. Other significant conditi	9 Unkni	own death but not	resulting	in the un	derlying ca	use nive	en in Part	1	23e Did tob	pacco use conf	ribute to t	he cause of death?
ords, P.O. B w requires that the de is been signed by the should be detached i	Ž	•				y 117 ti 10 ti 11	aoi iy ii ig ca	400 g. (o.,		_	_		ably 4 Unknown
rds, requir	Completed										24a. Was a			opsy findings available ompletion of cause of
i of Vital Records ing Physician: The law requi After this certificate has been tuneral director, page 2 should	E C					-					perform	ned?	death?	
E III T	Be C	25. Was case referred to medical					26.1	Place of	Death (C	heck on			<u> </u>	
Vita	.૦	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpatient 2	ER/OL	utpatient	3 🔲 DOA	Ot	her ₄ _ h	Nursing I	Home 5 F	Residence 6	Other	
J of Jing Ph After t	Ë	27. Manner of Death 1 X Natural 5 Panel		of Injury , Day,Year)	28b. T	Time of Inju	·		at Work?	- 1	3d. Describe h	ow injury occur	red	·
SiOr Mtend death death oy the	Satic	Felia	tigation						s 2 N					
Division of Vital Records, tal or Attending Physician: The law requires after death. al Director: After this certificate has been sited in by the funeral director, page 2 should the fine of the funeral director, page 2 should the funeral director.	Certification:	deter	not be 286. Place mined (Specify)	e of Injury - At h	nome, ta	rm, street,	factory, of	ice buil	ding, etc.	28	or Town, St		er or Rur	al Route Number, City
Hospit 24 hour Funer cely fill		4 Homicide 29a. Certifier 1 Certifying Ph	ysician: To the bes	st of my knowled	dge, dea	th occurre	d at the tim	e, date	and place	e, and du	ie to the cause	e(s) and manne	r as state	d.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exar	niner:On the basis and manner s	of examination			n, in my op	inion, d	eath occu					
	Ž	29b. Signature and title of certifier	11/					cense r				29d. Date sign		th, Day, Year)
		Jameste Vr	ne The	l				.C.M.	E.			March 5, 2	U11	
OK Out		 Name and address of person Margarita Korell MD. 	Assistant Med	•		900 W. I	Baltimor	e Stre	et, Balt	imore	MD 21223	3		
	ate	31. Date filed (Month, Day, Year)		egistrar's Signa					,					
Regist	rar	MAKIU	UII JOHN	m p	. 1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Wilford A Howard		ent of Health and Mental Hygie ate of Death	ne 2011 074/5
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) Wilford A.	Howard Mo	te of Death nth Day Year rch 4, 2011 3. Time of Death 0933 hrs
	4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 2 1 7 - 4 6 - 0 5 5 6		ate of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD
Aaryland 28a-f show any 1 at once. Octor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD	or Location Baltimore	10d. Inside City Limits 1※XYes 2 No
r death with the Maryland or items 23s or 28s-f sho must be notified at once. Funeral Director		10f. Zip Code 21215	10g. Citizen of What Country? USA
	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1f Yes, Giva Yaar 0r Dates:	13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican, 1 Yes 2 No specify:	
5-0036 led within 72 hours after death with the Maryland thygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	15 December 5 Education (Specify only highest grade completed) 40s	Decedent's Usual Occupation (Give kind of work do during most of working life. DO NOT use retired) Truck Driver	ne 16b. Kind of Business/Industry Transportation
21215-0036 uld be filed within 7 Mental Hygiene. marked other that c event, the Medica	Melvin Jakokson	Agnes	Middle, Maiden Surname) Jackson
O es de in in in		o. Mailing Address (Street and Number or Rural R 5330 Winner Ave., Ba	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus	1 Burial 2 X Cremation 3 Removal from State Final	of Disposition (Name of cemetery, pay or other place) journey crem. 3/11/2	
Ball permit Depart Impor	21. Signature of Funeral Service Licensee Dorota Marshall	PO Box 1413, B	tion Services altimore, MD 21203
Physician /Medical _xaminer.	Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascul		atory arrest, shock, or heart Approximate Interval Between Onset and Death
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.		
ted Insit Examiner	if any, leading to immediate rause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
	d.		
sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed at the this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - traction: To Be Completed by Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		23d. Date of delivery Month Day Year
P.O. Bc ss that the des gned by the s e detached fc	Part ii. Other significant conditions contributing to death but not resulting		Be. Did tobacco use contribute to the cause of death?
ds, P.C equires that een signed 1 ould be deta			1 Yes 2 No 3 Probably 4 ✔ Unknown 1a. Was an 24b. Were autopsy findings available
Division of Vital Records, tall or Attending Physician: The law requirers after death. a) Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed	25. Was case referred to medical	26. Place of Death (Check only on	autopsy performed? Yes 2 No 1 Yes 2 No e)
of Vitaling Physician After this certiuneral directon	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Ou	stpatient 3 DOA Other Nursing Home	5 Residence 6 Other:
trending Ph death. tor: After 1 y the funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ime of Injury 28c. Injury at Work? 28d. D	escribe how injury occurred
Division of Spital or Attending nours after death. The actal Director: Affilled in by the find Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa		ocation (Street and Number or Rural Route Number, City Town, State)
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificatic	29a. Certifier (Check only one) 2 Wedlcal Examiner: On the best of my knowledge, dea one) 2 Wedlcal Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the tir	ne, date and place, and due to the cause(s)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) March 5, 2011
1411	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Ba	altimore Street, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	all	
DHMH 17 Rev 1/2001 OCME 2006	ORI	GINAL	OCME

11-01750 Jacinta Henry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

растна пенту		1- For State Registrar	Star	te of Maryla		partment d ertificate d		and I	Mental	Hygiene	Reg. N	201	1 0/4/6
Physic Medical Exam		Decedent's Nam		Last)						2. Date of Month	Death Da	y Year	3. Time of Death
njediodi Exam		4a. Facility Name (a Henry (if not institution,	give street and nu	ımber)		4b. City, Tov	wn, or Loc	cation of De	March	4, 201	1 4c. County of De	
		301 McMechen Street Apt 811 Baltimore											
Funeral Director		5. Social Security	0 = 0 /	. Sex	7. Age (In yrs	s. last birthday)	If Under Months	_	If Under 24			Fo Fo	Birthplace (State or unic
Director		072-34		1 M 2 ¥F		74 Y		Days	Tiodis I	Oct	21,	1936	Country) Panama
any		Usual Residence o 10a. State	10b. County		10c. Ci	ity, Town or Loca	ation						10d. Inside City Limits
.	-										1 X Yes 2 No		
Maryland 28a-f show d at once.	Director	10e. Street and Nu		10f. Zip Code 10g. Citizen of What Cou								Country?	
the N 3a or S	Ξ	301 Mc	Mechen S	St; Apt 8	311		21	217				USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other thao "natural", or items 23a or 28a-f abo injury or other traumatic event, the Medical Examiner must be ootified at once.	Funeral	11. Marital Status 1 X Never Marrie			edent Ever in					Specify Yes or		14. Race - An White, etc	nerican Indian, Black,
er dea	골	3 Widowed		1 Yes	2 🗶 No					ispanic		1.	olack
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003(within iene. er tha	gm	-unk	1211	-unk		hous	se keep					hote1	
MD 21215-0036 4 2 should be filed within 7 th and Mental Hygiene a 77 is marked other than umatic event, the <u>Medica</u>	ပိ	17. Father's Name Headley		ast) unk-				18.1		me (First, Midd		en Surname)	ink.
212 uld be Menta marke	To Be	19a. Informant's Na		(Type, Print)		19b. Mailir	ng Address (Street an		_	Hill Number	City or Town St	ate, Zip Code)
AD 2 sho th and 27 is umati		Wayne	Henry -	son			Olney			Bowie,	_		ato, asp oddo/utile
re, land Heal	li i	20a. Method of Disp 1 X Burial 2		2 Demovel for		o. Place of Dispo crematory or o	sition (Name			Date	200	. Location - City	or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If itel najury or other tr.		4 Donation 5	TX Other Spec	_	I Mi	t. Zion		ery	3-	19-11]	Baltimor	e, Md.
Salti ermit. epartn mport ijury		21. Signature of Eur	neral Service Lic	maked III	Dimecto	r G	Name and Ad	dress of F	Facility C	tate An	459	yi Poard	Pass
		23a. Part Enter th	o disease or to	molications that or	oused the deal	1 -	655 W.	Bal	timor	e St; B	alti	more, M	D 21201 21229
Physician /Medical		failure. List onl	ly one cause on	each line.						or respiratory	arrest, s	nock, or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (I or condition resulting		Due to (or as a		_	liovasculai	Disea	se			·	Death
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d Sit	Examiner	(Disease or injury the events resulting in a	nacmuated	Due to (or as a	consequence	of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ig E			d	0 11_1	2 15_10	105 2	00.21	2 202	fb c01	2 2	10 11	
60, ate be e: hysiciar e burial	edic	UNPENDED					• 1 7 D – Z	UC, ZZ		III 831.			
Sox 68760, leath certificate be exe c attending physician for use as the burial -		23b. Was decedent past 12 months		23c. If yes, o			etal death	3 E	Ectopic preg	nancy	2	3d. Date of deliv Month	ery Day Year
Box 6 e death cel	sicie	1 Yes 2 ✓ N	_		ant at time of o	d4b	ther (Specify,				Î		
D. B.	Phy	Part II. Other signif		a oursion		resulting in the	underlying ca	use given	in Part I	23e Die	d tobacc	o use contribute	to the cause of death?
P.O. es that the igned by	by							200 g. 10,					robably 4 Unknown
requir	Completed by				_					24a. Wa			autopsy findings available
eco he law te has ge 2 sl	d m									ре	topsy	death'	
tal Recises: The certificate ector, page		25. Was case referr	ed to medical				26.6	Place of D	Death (Chec		s 2 🗸	No 1	Yes 2 No
of Vital Records, og Physiciao: The law requir ufter this certificate has been s neral director, page 2 should	e Be	examiner? 1 ✓ Yes 2	2 No	Hospital: 1 In	npatient 2	ER/Outpatient	3 DOA	Othe	er ₄ Nurs	sing Home 5	Resid	lence 6 🗸 Ott	ner: Scene
	Ë	27. Manner of Death 1 ✓ Natural		28a. Date of (Month,	of Injury Day,Year)	28b. Time of		Injury at	Work?			jury occurred	
Division tal or Atteodi s after death.	Certification:	2 Accident	5 Pending Investiga	ation					2 No				
Divis pital or At ours after d eral Direct filled in by		3 Suicide	6 Could no	ot be	of Injury - At I	home, farm, stre	et, factory, off	ice buildi	ng, etc.	28f. Location or Town		and Number or I	Rural Route Number, City
Tospit 4 hour		4 Homicide 29a. Certifier		Ician: To the best	of my knowled	dae death occu	rod at the tim	o data a	nd place, or	od due to the es			-1
Di To the Hospital within 24 hours at To the Funeral I completely filled	edical	(Check only one) 2	Medical Examin	er:On the basis of	f examination	and/or investiga	tion, in my op	inion, dea	ath occurred	at the time, da	iuse(s) a ite and p	lace, and due to	the cause(s)
F. 2 F. 8	Me	29b. Signature and t	itle of certifier	and manner sta	ated.		29c. Li	cense nur			29d	Date signed (N	fonth, Day, Year)
		Then	P. 71	1 Kin	S TR	LAL S	9 0	.C.M.E	0	OME	Ma	rch 7, 2011	
	-	30. Name and addre					0001115		0				
		Theodore M. 31. Date filed (Month			of Medical gistrar's Signat	Examiner		itimore	e Street, l	Baitimore, N	MD 212	223	
St Regist			n, Day, Year)		Justian S Olgital	ge par	Col						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year THOMAS JAMES IRELAND 2011 <u>11:28a</u>™ Medical March 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death MANOR CARE-LARGO PRINCE GEORGES **LARGO** 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min. March **Director** 217-24-9352 MARYLAND 77 Yrs. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2XXNo MARYLAND PRINCE GEORGES NEW CARROLLTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5546 KAREN ELAINE DR. 20784 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 Married ild be filed within 72 hours after Mental Hygiene. Maryland 21215-0036 If Yes, Give Year or Dates 51/54 1 ☐ Yes 2 X No Specify: Widowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SELF 9th grade JANITORIAL ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY SNOWDEN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic CHARLES IRELAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trina Ireland/Daughter 5546 Karen Elaine Dr., New Carrollton, Md. 20784 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) GARRISON FOREST 03-10-11 OWINGS MILLS, MARYLAND 21. Sign were of Funeral Service Licer Name and Address of Facility ILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 206 W NORTH AVE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) men **,**≁Medical **Examiner** Sequentially list conditions cause. Enter Underlying death certificate be executed Cause (Disease or linjury physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 autopsy perform death? After this certificate Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident work 1 \square Yes 2 🗌 No after death Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one 29b. Signature and title of certific 29d. Date signed (Month, who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Ste tanoves 32. Registrar's Signature MAR 10

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** 115EVIN MARCI /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1 🗙 M 2 🗆 F Yrs 212-31-5969 52 07/24/1958 Turkey Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov Examiner must be notified at 1 Yes 2 No Director MD Baltimore co. Owings Mills 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō 10821 Sherwood Hill Rd. items 23a Funeral 21117 Turkey 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 🙀 No Specify ģ Specify: White 3 Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation injury or other traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade and Mental Hygiene. College (1-4 or 5+) Cosmetic Hairdresser Y (61.6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ismet Isik Neriman Capci ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Neriman Isik(mother) 10821 Sherwood Hill Rd., Owings MTlls, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Istanbul Cemetery 03/12/11 Istanbul, Turkey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens TsTamper Tuneral Services, Inc. Toas 251 De Kalb Ave., Brooklyn, NY 11205 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RRHO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months?

1 Yes 2 No Live birth 3 - Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 has s certificate has director, page 2 1 TYes 2 🗌 No 1 Tyes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home \sum 5 \sum Residence 1 Inpatient 2 ER/Outpatient 3 DOA မ 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death.

Director: Aft
d in by the fu 1 🗌 Yes 2 🗌 No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) 24 hours a Hospital 29a. Certifier 💢 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hound To the Funer completely file Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RE9-000 30. Name and address of person pleted cause of death (Item 23a) (Type, Print)

15 V

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar

Registrar's Signature

MAN I W ZUIT CO

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2ð I 1 Inez M. Johnson 11:52 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 05 01 1926 1 □ M 2 🖾 F Days Hours Min. 84 Yrs DC **Director** 578-30-1827 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 ₺ Yes 2 □ No MD Temple Hills Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3906 Triton Court 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Johnson Sarah Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne C. Prince/Great Niece B906 Triton Ct. Temple Hills MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resurrection 3-15-2011 Clinton Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of FacilityJohn T. Rhines Funeral Home 3005 12th Street NE Washington DC 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE INFARC TION Physician/ MYO CARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERIMERAL ARTERY DISEASE 1 Yes 2 No 3 Probably Unknown page 2 should CONGETIVE HEART 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? Atter this certificate has performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Atter this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 0064986 3/7/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death PURNELL Physician/ JOHES Month O 3 O 8 11 06 AM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAMARITAN HOSPITAL BALTIMORE **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 212-60-814 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Department of Health and Mental Hygiene. "The hours after death with the Maryland Important: If item 27 is marked other than "natura!" any injury or other traumatic events." 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE M.D1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral FRANKFORD AVE 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Divorced BLACK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) YRIVATE MAINTENANCE SUPERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ MACON JONES anitA JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Ann JONES 4806 FRANKFORD AVE. BALTO, MO. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕊 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST BALTIMORE, MD 4 Donation 5 COther (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCVS 0 ROAD. BALTIMORE, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OSTEOMYELITIS WEEKS Sequentially list conditions, if any, leading to immediate trans. Enter underlying Cause (Disease or linjury Examiner INFECTIVE ENDO CARDITIS WEEKS that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by REGURGITATION AURTIC VALVE 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HEPATITIS C 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an e 2 s COPD Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **N**o ၉ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one, 29b. Signature and title of certifier only one) 29d. Date signed (Month, Day, Year) S. A. KOLGE var RESOOD 08/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

S. A. KOLGE

MAR 10

31. Date filed (Month, Day, Year)

LOCH

5601

RAVEN

BLVD

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			epartment of Health and I Certificate of Death	Mental Hygiene Reg. No	2011 0/401
Physic	ian/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Med		TOBY LEE JACKSON		March 6	^{Ay} 2011 12:09 p ^M
Exam	iner		4b. City, Town, or Location of Death	4c	. County of Death
-		712 CROSBY RD. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthrick)	BALTIMORE av) If Under 1 Year I If Under 24 Hrs.		BALTIMORE
Funera Directo	_	5. Social Security Number 124-52-5822 6. Sex 1 M 2 D F 7. Age (In yrs. last birthdom) 7. Age	Mantha Dove House Min	8. Date of Birth (Month, Day, Year) SEPT 2 196	9. Birthplace (State or Foreign Country) NEW YORK
Mo.		Usual Residence of Decedent			JO _ I NEW TORK
yland f show ed at	惊	10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
Mar 28a-	jre	MARYLAND BALTIMORE	BALTIN	1ORE	1 ☐ Yes 2 🕅 No
ith the	a [10e. Street and Number	10f. Zip Code		tizen of What Country?
ath w	Funeral Director	712 CROSBY RD. 11. Marital Status 12. Was Decedent Ever in U.S.	21228		J.S.A.
er de or ite	by F		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	 Race - American Indian, Black, White, etc.
rs aft	ed k		1 ☐ Yes 2 🛣 No Specify:		Specify: BLACK
2-C	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of work	16b. K	ind of Business Industry
Thin 7. The. than the Me	E O	Elementary/Seconday (0-12) College (1-4 or 5+)	e. DO NOT use retired)		
VIBING 21213-UU30 Id be filed within 72 hours after death with the Maryla Mental Hygiene. arked other than "natural", or items 23a or 28a-fs atte event, the Medical Examiner must be notified	Be		TRUCK DRIVER		CANADA DRY
land Z1Z13-UU36 be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	卢	TOBY JACKSON		e (First, Middle, Maiden : E ANN SMITH	Surname)
Marylan should be file and Mental 7 is marked of raumatic eve			ailing Address (Street and Number or Run		Town State Zin Code)
ire, Maryla 1 and 2 should be if Health and Men item 27 is marke			2 Crosby Rd., Balti		
of Health of Health fitem 27		20a. Method of Disposition 20b. Place of Di			ocation - City or Town, State
Page ment ant: I				1-2011 BA	LTIMORE, MARYLAND
Dallillory permit. Page 1: Department of F Important: If its any injury or of once.		21. Sign, are of Funeral Service Licensee	22. Name and Address of Facility	77.77.	
		Was View Cifs	WILLIAM NORTH AVEN	MMUNITY FUR	TERAL HOME P.A.
		23d. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
h_sician Medica		Immediate Cause (Final disease or condition resulting in death)	AHSVD		Onset and Death
Examine		Due to (or as a consequence of):			
to tender	je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
uted d ansit	Examiner	cause. Enter Underlying			
exect an an rial-tr	Ä	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
Attending Physician: The law requires that the death certificate be executed at death. Sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	dical	d			
artifica ling p	Physician/Me	IF FEMALE:			
ath certifica attending p	cian	23b. Was decedent pregnant in the past 12 months? 1 Use all time of death 11 pregnant at time of death 12 pregnant at time of death 13 pregnant at time of death 14 pregnant at time of death 15 pregnant at time of death			23d. Date of delivery Month Day Year
the de	ysi	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 U Other (specify)		Worth Day real
es that the designed by the signed the signed that the	by Pi	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
uires n sign		Hyperlipiden	ria	1 ☐ Yes 2	No 3 Probably 4 Unknown
aw require as been si 2 should	plet	Hyperlipiden Hypothynoidis	500	24a. Was an	24b. Were autopsy findings available
The la	Completed	7		autopsy performed?	prior to completion of cause of death? 1 Yes V No
sian: ertific ctor,	Be	25. Was case referred to medical examiner?	26. Place of Death (Check		1 10 10 20110
hysic this o	ျ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	- I are in igno	me 5 Pesidence 6	Other (Specify)
ding F	ate	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) injury	/ work?	28d. Describe how injury	occurred
death death ctor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No		
after Dire		4 Homicide determined building, etc. (Specify)	street, factory, office	City or Town, State)	l Number or Rural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. Or the Funeral Director After this certificate completed filled in by the funeral director, pag	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	h occured at the time, date and place, an	d due to the cause(s) and	d manner as stated.
the Hk iin 24 he Fu ipleter	Med	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at	the time date and place	and due to the cause(s) and manner stated
With 10 t		29b. Signature and title of certifier	29c. License number	29d. Date	e signed (Month, Day, Year)
		MUHalnesus	046676	Mor	ch 8, 2011
hV		30. Name and address of person who completed cause of death (Item 23a) (Type	, ,		
Sta	to	Dr. Michaelle H. Holmes, Md., 183 31. Date filed (Month, Day, Year) 32. Registrar's Signature	8 Greene Tree Rd.,	Suite 135,	rikesville Md. 2120
Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 0 2011 August A. Sauks			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Elias Kemelhor March 04 2011 2:08 P^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Suburban Hospital</u> Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 05/19/1919 1 🛛 M 2 🗆 F **Director** 085-09-3365 91 <u>New York</u> Usual Residence of Decedent or 28a-f show e notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Montgomery Bethesda 10e. Street and Number r items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 6211 Redwing Court 20817 "natural", or item fedical Examiner ה 12. Was Decedent Ever in U.S. Armed Forces?

1 \(\overline{\Omega} \) Yes 2 \(\overline{\Omega} \) No \(1941-\) 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Year or Dates 1945 White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturenty injury or other traumatic event, the Medical Longe. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+Engineer Aero Space Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Louis Kemelhor Rebecca Edelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley P. Kemelhor / wife 6211 Redwing Ct. Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 🛚 Burial 2 🗆 Cremation 3 🛣 Removal from State cemetery, crematory or other place) King David Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 03/07/2011 Falls Church, VA 21. Signature of Funeral Service License 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville. <u>Kurt Blake</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) envenionia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🖫 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 W No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖒 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🖷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) 1)006(30) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Atul Rohatei M.D.
31. Date filed (Month, Day, Year)

2:08pm

2011

8600 Old Georgetown Rd. Bethesda, MD 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :30A M Paul James Kuczo Medical **Examiner** 4b. City, Town, or Location of Death, 4c. County of Death 020 Sour COMICO If Under If Under 24 H/s Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 049-22-5031 Days ^{Year)}1930 1 X M 2 □ F pril 16 Months Director Yrs Connecticut Usual Residence of Decedent shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Worcester Berlin 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21811 USA 9 Chester St. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1954-Completed by 1 Never Married 2X Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 K No Specify: 1956 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hou. Department of Health and Mental Hygiene. Important; if item 27 is marker. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul James Kuczo Sr. Anne McKeever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Kuczo - wife 9 Chester St; Berlin, Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) Signatur of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final €nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury r as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No g 🗌 Unknown à signed by I pe deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 20 No Other: ၉ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) (C Sh After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: lal-e 1 Natural 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral L Medical 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signa and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 631 99 Name and address of person who completed cause of death (Item 23a) (Type, Print) OG SH VOHLA SALISBURY 910 EASTERN SHURE

State

Registrar

31. Date filed (Month, Day, Year)

MAR 10

2011

KUCZO,

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 19b per fh 2913 3-10-11 vt State of Maryland / Department of Health and Mental Hygiene 11 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ,55 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Hours Country KAZAKHSTAN 1171071936 **Director** 217-59-7525 74 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X☐ Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3615 FORDS LANE, #403 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed Specify: 3 Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ DOCTOR MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ MTKHATT. KRISHTAPOV YEKATERINA VINARSKAYA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #403, ANRI SHTEYNBOK/HUSBAND 3615 FORDS LANE, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/08/2011 BALTIMORE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS.. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition 180100 Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnar 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the atte should be detached for in the past 12 month Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has eral Director: After this certificate I filled in by the funeral director, pag performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: မြ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of eath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hatural (Month, Day, Year) 5 Pending work?
1 Yes 2 No 2 Accident
3 Sulcide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Destifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Ite 010 000 31. Date filed (Month, ₽ay, Year) -State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NORMAN MARCH 201 T 04:45P M KLAWANSKY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME PIKESVILLE BALTIMORE Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Birthpic Country) MD Days Hours Min 1270671925 **Director** 219-18-1134 85 Yrs Usual Residence of Decedent 23a or 28a-f show "natural", or items 23a or 28a-f sho 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4156 CRESTHEIGHTS ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Divorced 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATION CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ SAMUEL KLAWANSKY **JEAN** GORONZIK permit. Page 1 and 2 should Department of Health and Important: If item 27 is many injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE BRESSLER / SISTER #3, PIKESVILLE, MD 21208 7 POMONA WEST, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State BETH TSAAC 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) ISRAEL CONG. 03/07/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ESPIRA hysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner UMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 5 Other (specify) Pregnant at time of death Month Day Year 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has ! autopsy perform 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pendina Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier (Check only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

MAR 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard B. CHEN, M. D.

2011

Registrar's Signat

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

50

29d. Date sign

Amend #5, per File G913 3/16/11 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Day Kauffer 07 20 Year 5:39 Victor Haines Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 213<u>-62-3273</u> If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 **X** M 2 □ F Days Hours Min. Months Month, Day, Year, 113/1956 Director 54 Maryland Usual Residence of Decedent items 23a or 28a-f shov 10a, State 10b County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Darlington 1 Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4041 Conowingo Rd., Lot 59 21034 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 \(\bar{\Lambda} \) Yes 2 \(\bar{\Lambda} \) No If Yes, Give Year or Dates. Black, White, etc. ò Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: SpecifWhite Health and Mental Hygiene. tem 27 is marked other than "natural", 3 Widowed 4 Divorced Army 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Tool and Die Machinist 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Junior Kauffer Anna Marie Brown 2804/2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Debora Kauffer / Wife 4041 Conowingo Rd, Lot 59, Darlington, MD 21034 20a. Method of Disposition 20c. Location - City or Town, State West Chester, 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State R.A. Ferris & Co. 3/9/2011 4 Donation 5 Other (Specify) Pennsylvania 21. Signatur Jun ral Service Lice 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21001 Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Witio disease or condition Medical resulting in death) Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a co Cause (Disease or linjury that initiated events resulting in death) Last and use as the burial-trai Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year ☐ Yes 2 ☐ Unknown 9 Unknown MOODIFICE Part II, Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? After this certificate 2X No Yes 1 Tes 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? NOCOR. ၉ 2 🗌 No Other: 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🔲 Yes Accident
Suicide 2 No 24 hours after death Funeral Director: Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Expurier: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Expurier: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Expurier: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F only one 29b. Signature and title of Name and who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:05 Alice Loverde March 5 2011 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death JMM H Catonsville Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 Months Days Hours 219-20-7261 07/14/1928 Director Yrs Maryland Usual Residence of Decedent 23a or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Arbutus 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1128 Linden Avenue 21227 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3[™] Widowed 4 □ Divorced White Specify: Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done in life, DO NOT use retired) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Factory Worker Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ 27 is marker Carl Gerecht Anna Greensfelter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Joseph L. Loverde (Son) 7760 Catherine Ave., Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Loudon Park Cemetery Ponation 5 Other (Specify) 03/10/2011 Baltimore, Maryland 4 re of Funeral Service Lic in ee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 2012 Ctiv Hoca manll Medical resulting in death) Due to (or as a consequence of **Examiner** tementic YOUR Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year ≥No 1 ☐ Yes 2**
9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate I 1 Yes 2 No eral Director, After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1-Natural 5 Pending work? Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medica 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 21229 MY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2011 March 4, Elmer 9.35 AM Leek Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ridgeway Manor Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. (Month 3 Jay, 1920) Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, 1 ★ M 2 □ F Country Maryland 216-03-1913 91 Director Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5207 Shelbourne Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ģ 1 Never Married 2 Married Yes Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Completed 3 Divorced Specify: white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ge 1 and 2 should be filed within 72 t of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas J. Leek Catherine Dash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Leek-Wife 5207 Shelbourne Road, Baltimore Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1XXBurial 2 Cremation 3 Removal from State Loudon Park Cemetery Mar.9,2011 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Forerar Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. ckere 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 14 PERTENSIVE CARDIOVASCULAR disease or condition resulting in death) ONG STANDING Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as 1 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death
Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ FIBRILLATION, CONGESTIVE HEART Records, Completed 1 Yes 2 No 3 Probably 4 Unknown FAILURE TO THRIVE, CHRONIC 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performe death? DISEASE. this certificate KIDNEY Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💆 No Other: 4 12 Nursing Home 5 - Residence 6 - Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pt n 24 hours ofter death. e Funeral Director After the letted filled in by the funeral Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted 1 2 Medical Examiner: On the pasts of examination and/or investigation, it my spinior, scale and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2.

To the F
complet only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Komal K. Dana m. D 3 455 Ralto, Md 21229 Wilkens Ave.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 07489 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Margaret Cosgrove McDonough 2019 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Cen. Glen Burnie 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕱 F 217 38 0100 Hours 0170571941 70 Maryland Director Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel Glen Burnie Maryland 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 104 Crain Highway Apt. 887 21061 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give 21215-0036 filed within 72 hours after 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home 12th Be other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve and Mental ဥ Robert Micucci Rita Felice MARCHAN Baltimore, Mar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Pollay 20 Hammerlee Rd. Apt. 308 Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 03/10/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Vicense 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that care detected the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition mone Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed Was an 24b. Were autopsy findings available Was an autopsy performed? cate has l prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No I Director: After to in by the funeral 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending injury Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completed filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original dark. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 10 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

MCDONDE

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 07490 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 07 MIRSKAYA 2011 12:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE Social Security Number If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 Hours 1171571918 215-33-8576 92 **BELARUS** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 PICKERSGILL SQUARE 21117 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MOSHEY RIVKIN DVOIRA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 PICKERSGILL SQUARE, OWINGS MILLS, MD GREGORY MIRSKY/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARLINGTON CHIZUK AMUNO CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/08/2011 BALTIMORE, MD 21. Signature of Funeral Ser 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part a Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ner

Physician/ Medical Examiner

Funeral

Director

ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other transmissions.

Division of Vital Records, P.O. Box 68760

nding physician and use as the burial-tran ned by t s been signe should be c page 2 24 hours after dear

the Hospital or Attending Physician; The law requires that the death certificate be executed

Medical Exami	cause. Enter Underlying Cause (Disease or ini)ury that initiated events resulting in death) Last	c. Halabean 31500	DEQ.
hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year
completed by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
စ္	25. Was case referred to medical	26. Place of Death (Che	
<u>о</u>	examiner? 1 Yes 2 No	Hospital: Other:	Home 5 ☐ Residence 6 ☐ Other (Specify)
ricate;	27. Manner of Death 1	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
al Certi	3 □ Suicide 6 □ Could not b 4 □ Homicide determined	e 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
edic	29a. Certifier (Check Z Medical Exam	sician: To the best of my knowledge, death occured at the time, date and place, a iner: On the basis of examination and/or investigation, in my opinion, death occurred in the basis of examination and/or investigation.	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

State Registrar

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30. Name and address of

29b. Signature and title of certifie

Date filed (Month, Day, Year)

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ated cause of death

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ STEWART JOHN McENTEE March 12:14P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Director 216-03-2647 95 09/27/1915 Mary land Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho Important: If item 27 is marked outher than "natural", or items 25a or 28a-f sho Important in Items 25a or 28a-f should be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits 1 Tes 2 XX Marvland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 West Seminary Avenue 21093 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1XXX Yes 2 □ NoWW [] Black, White, etc þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify. White 3 Divorced Completed Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dispatcher Sunpaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Peter James McEntee Fannie Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart P. McEntee 414 Powhaton Hill Place, Manakin-Sabot, Virginia 23103 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 03/10/2011 Owings Mills, Maryland 22. Name and Address of Facility MITC ell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph_sician/ riset and Death disease or condition gasto intestino Medical resulting in death) Die to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Physician/Medical Examiner Due to for as a consequence of igned by the attending physician and be detached for use as the burial-trans Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year 1 Yes 2 L g Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate within 24 hours after deaun.

To the Funeral Director: After this certification in the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signatu 29c. License number 29d. Date signed (Month, Day, Year) 7011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATTUES MO

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg No 2 0 1 1 7 4 9 2											071.02
		Registrar 1. Decedent's Name (First, Middle, Las	4)		Cer	tificate of E	Death		Reg. No	401		W 2 1 0 1-4
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Funeral		5. Social Security Number 6. Se		e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth		9. Birthplac	ce (State or Foreign
Director		217-24-0322 Usual Residence of Decedent	LIM 2 KAIF		81 Yrs.	Months Days	Tiodis Will.	OCT 25	192	29 3	SOUTH	CAROLINA
land show d at	٥Ľ	10a. State 10b. County		10c. Cit	y, Town or Loc	cation					10d	. Inside City Limits
Marylk 18a-f	Director	MARYLAND N/A				BAI	LTIMORE					XX Yes 2 ☐ No
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th with ms 23 must	Funeral	1819 WENTWORTH				2123				S.A.		
r deal or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 \(\sum \) Yes 2 \(\begin{align*}{c} \begin{align*}{c} \text{Yes} \\ \text{2} \(\begin{align*}{c} \text{Ves} \\ \text{Align*}	ever in U.S			spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)	.		American White, etc	
s afte ral", c	q pe	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	MAO	1	I ☐ Yes 2XXNo	Specify:			Specify:	BLACK	
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ed wii Hygie other ent, tl	Be (12yrs. 17. Father's Name (First, Middle, Last)	5yrs		SCHOO	L TEACHEI	18. Mother's Name	e (First Middle		OUCAT	LON	
be fill lental rked tic ev	입	WILLIAM H. WHI	ГТ					CARTE		ourname,		
should and N is ma		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	ng Address (Street a	and Number or Rura			Town, Sta	te, Zip Coo	le)
nd 2 s ealth m 27		W. Maurice McCoy,	/Son		1819	Wentworth	n Rd., Ba	1timore	e, Ma	ırylar	nd 21	234
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Inpopartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition XX Burial 2 Cremation 3	Removal from State			sition (Name of natory or other place	e) [Date		ocation - C	-	
it. Pag irtmen irtant injury		4 Donation 5 Other (Specify		GAR		FOREST	03-1	5-11	OWIN	IGS M	ILLS,	MARYLAND
perm Depa Impo any i		21. Signature of Funeral Service License			22 W	Name and Addres	BROWN CO RTH AVENU	фмииіту	Y FUN	IERAL	HOME	P.A.
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Physician/		Immediate Cause (Final disease or condition	ME	LA	-NOI	YA W	ITH 1	18TA	CTH	7.0%		terval Between nset and Death
Medical Examiner		resulting in death)	a. Due to (or as a	a consequ	ence of):	000	1: 101 0	1/2	-)	A .	
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ending sath. or: Aft. he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	, rear)	injury	M 1 🗆	Yes 2 No					
or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the bu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At ho	me, farm, stre	eet, factory, office		28f. Location (or Rural Ro	ute Number,
pital o		29a. Certifier 1 Certifying Phys	inian. To the heat of	mu knowle	adaa daath a	aggured at the time	data and place are			-l		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurse	ner: On the basis of ex	kamination	and/or invest	igation, in my opinio	n, death occurred at	the time, date a	and place,	, and due to	the cause	(s) and manner stated.
To the within To the comp	2	29b. Signature and title of certifier			talomodgo, d	29c. License		o, and due to tr		te signed (/		
		18. Wol	or 1	19		030	8053		03	107	7/S	1011
lav	•	30 Name and address of person who co	ompleted cause of de	eath (Item	23a) (Type, P	rint) Au D				/		
Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signati	ure	1CON U			· · · · · ·			
Registra	ır	MAD 1 0 2011 /2		BOW	Ces							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MOSES, MILES Month 0.3 06 2011 10:00p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6638 Whitmore Ct. Apt 160 Anne Arundel Co. Glen Burnie Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 1 M 2 1 F Months Days Hours Min 0476571929 Mary land Director 220-22-5964 81 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland must be notified at Director 10d. Inside City Limits 1 ☐ Yes 2 🔀 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Completed by Funeral items 23a 6638 Whitmore Ct., Apt 160 21060 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No ō 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3
Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Masonry Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jacob Miles Annie Bradshaw permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tillie Lynn(daughter) 394 Kinwood Rd., Arnold, MD 21012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) □ Burial 2 □ Cremation 3 □ Removal from State 03/11/11 Cedar Hill Cem. 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funeral Service sicensee *අ*ර්යු වේර්ල් මෙස්රිම් වෙන Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 23a. PArt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or h. by failure. List only one cause on each line. Immediate Cause (Final METAST CANCER Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 3 YEARS Examiner 5 squantially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnal-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) မ 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛚 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier ONOCOLOGY, M.D

Registrar

State

DHMH 17 Rev 7/2009

ecurity Blud., Baltinure, MD 21244

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHALID M.D.

11-01565 Lewis Meadows Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

_ewis Meadows	S	State 1- For State Registrar	ate of Maryla		artment o		nd Men	tal Hygiene	20 Reg. No.	0749
Physic		1. Decedent's Name (First, Middle	e,Last)					2. Date of D	eath	3. Time of Death
Medical Exam	ine	zemze meddews						Februar	y 25, 2011 Year	1000 hrs
		4a. Facility Name (if not institution 339 W. Antietam Street	. •	mber)	Į.	1b. City, Town,		of Death	4c. County of	
F		5. Social Security Number		7. Age (In yrs. h	and binds day of	Hagerstov		To Barret	Washingt	
Funeral Director					• •	If Under 1 Ye Months Da		Min.		Birthplace (State or Foreign
		217-82-5437 Usual Residence of Decedent	1XM 2F	4	·5 Yrs			Apri	L 4, 1965	Country)Maryland
*ny		10a. State 10b. County	-	10c. City,	Town or Locat	on				10d. Inside City Limits
*	L	MD Wash	ington	На	gerstow	n				1 Yes 2 X No
4aryland 28 n-f show Latonce,	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?
21215-0036 Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at once.	튭	339 W. Antiet	am St.			2174	.0		USA	
ms 23	Funeral	11. Marital Status		edent Ever in U.				gin? (Specify Yes or I		American Indian, Black,
death or ite	Š	1 X Never Married 2 Ma	1 Yes	2 X No	li Y	es, specify Cub	an, Mexican,	, Puerto Rican, etc.)	White,	etc.
s after ral", riber	_ ≦	3 Voidowed 4 Divo	rced If Yes, Give Year or Dates:		1	Yes 2 X N			Specify: V	
136 thin 72 hours on the contraction of the contrac	E E	15. Decedent's Education (Spec Elementary/Secondary (0-12)	ify only highest grade		16a. Deceden during me	s Usual Occup est of working lif	ation (Give l e. DO NOT	kind of work done use retired)	16b. Kind of Busi	ness/Industry
36 nin 72 Ethan dical	를	12		4015+)						
d with	Completed	17. Father's Name (First, Middle,	_ast)		car	et clea		s Name (First, Middle		ing business
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (Wayne Lewis Me	eadows					Irene Kin		
	ပ	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (Stre	eet and Num	ber or Rural Route N	umber, City or Town,	State, Zip Code)
5 2 4 2 8		Peggy Smith -	- sister					eneva, IL		
Baltimore, I bermit. Pages I and Department of Heali Important: If item		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from	m State 20b. F	Place of Disposi rematory or oth		emetery,	Date	20c. Location - C	ity or Town, State
Baltimo permit. Page Department Important: injury or otl		4 Donation 5 2 Street Spe	ecify: in stat	34	ent Cre					Maryland
3alt ermit Separt mpor njury		21. Signature of Funeral Service L ROTTa Ld	icensee	Virecto:	22. N Mar	ame and Addres	ss of Facility unera	State Ang	Amy Boorg	Harford Road
_ =====		23a Part I Enter the disease or o	MACL	used the death	Raj	imore ^B ,	Mary	1568 212 12	ltimore, N	D 21201
Physician /Medical		23a. Part I. Enter the disease, or or failure. List only one cause of Immediate Carse (Final disease	n each line. At l	neroscl	erotic	Cardiov	ascula	ar Disease	and	Approximate Interval Between Onset and
≟xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a c	consequence of	h h	ed by n	ypotne	ermra —		Death
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760 cate b physic he bu	Me	IF FEMALE:	23c. If yes, ou	utcome of pregn	ancy				23d. Date of de	livery
OX 68760 eath certificate by attending physical or use as the bu	cian/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bin	th nt at time of dea	···	al death 3	Ectopic	pregnancy	Month	Day Year
Box 68760 e death certificate b the attending physical for use as the b	Physic	1 Yes 2 No 9 Unkn			5 Oth	er (Specify)				
O. B. at the de 1 by the tached f		Part II. Other significant condition	ns contributing to d	death but not re	sulting in the ur	derlying cause	given in Par	t I. 23e. Did	tobacco use contribu	te to the cause of death?
Division of Vital Records, P.O. rat or Attending Physician: The law requires that this after death. al Director: After this certificate has been signed by red in by the funeral director, page 2 should be detach	d b							1 🗀 Ye	es 2 🗸 No 3	Probably 4 Unknown
rds requi	Completed							24a. Was		re autopsy findings available
eco he law tte has	ᇍ							auto perf 1 ✓ Yes	ormed? dea	
Vital Rec ysician: The his certificate director, page	Ö	25. Was case referred to medical				26.Place	e of Death (Check only one)	2 NO 1	Yes 2 No
Vita	P P	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inc	patient 2 1	ER/Outpatient		IOthor -	Nursing Home 5	Residence 6	Other: Scene
n of \ding Ph		27. Manner of Death	28a. Date of (Month, D	Injury Day, Year)	28b. Time of In	ury 28c. Inju	ry at Work?		how injury occurred	
trendi feath.	읉	1 Natural 5 Pendir 2 X Accident Investi	g fd 2-2	25-11	fd 1:00	am	Yes 2 🗶	" enviro	exposed to nment	cold
ivisic or Atte after dea Directo	Certification:	3 Suicide 6 Could	not be 28e. Place	of Injury - At hor			ouilding, etc.	28f. Location	(Street and Number of	Rural Route Number, City Antietam St.
Di ospital hours a necral I		4 Homicide determ	(Opecany)		in woo			Hagers	town, Md.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the broad page.	<u>ca</u>	(Check only Certifying Phy	sician: To the best of ner: On the basis of	of my knowledge examination and	e, death occurre	ed at the time, d	ate and plac	e, and due to the cau urred at the time, date	ise(s) and manner as	stated,
To 1 with To 0	Medical	29b. Signature and title of certifier	and manner stat	ted.		29c. Licens				(Month, Day, Year)
		Vo	w. (\ 1	1		O.C.			February 26,	
	ŀ	30. Name and address of person w	ho completed cause	of death (Item 3	23a)	1			. 55,00,	
			Assistant Medic	,	,	Baltimore S	treet, Bal	timore, MD 212	23	
St	ate	31. Date filed (Month, Day, Year)		strar's Signature						
Regist	rar	MAD 1 0 201	7 Bound	1 8.	LIMAN					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Joyce Elaine McMillan /Medical Marcu 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Agnes Hogsita 1 Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 59 Yrs. 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Hours Days 214-60-4891 1 □ M 2 🖾 F Director Sept 1, 1951 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location Director Elkridge MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6350 Orchard Club Dr; Apt 101 21075 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 ∐Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Inez Aldrich Eugene Hufnagle ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Abell - daughter PO Box 183; Maxwellton, West Virginia 24957 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signatur Funeral Similo Licensee 22. Name and Address of Facility State Antomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (1991 **Physician** Chronic Obstructive Pulmonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Broneligenic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed Healthcare Associated attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: JOYCE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, MC MILLAN. peen 24a. Was an autopsy performed? 1 □Yes 2 ☑No page 2 s certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1∐Yes 2XXNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident neral Director: , filled in by the f 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled i

23d. Date of delivery Day Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 □ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Everyn Gatheana MD P23490 March 5 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GATHECOTA 900 S CATON AVE MD 21229 BALTIMORE 31. Date filed (Month, Day, Year) 62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

8:45 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2X No

Approximate Interval Between Onset and Death

Maryland

white

hospitality

2011

Registrar

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 935 Corbett Napier march 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med Anne An Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Days Min. 1 € M 2 □ F Hours Feb. 21 1940 220-36-0058 Director ΚY Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3600 Mountain Road 21122 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene is marked other th Plumber/Mechanic Plumbing/Auto 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or not ဂ္ Napier Corbett Sr. Marybelle Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian A. Napier 222 Hollywood Court, Glen Burnie, MD 21060 (son) 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) March Glen Haven Cemetery Glen Burnie, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service License 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one peuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** ro extension Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical The law requires that the death certificate be as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Year 5 Other (specify) Day Pregnant at time of death ned by the a e detached f g 🗌 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 🔽 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore

Registrar DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MARZEH Medical 4a. Facility Name (if not institution, give street and number) Examiner M 4b. City, Town, or Location of Death 4c. County of Death VOILTHWEST COUTEN 6. Sex If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 🗆 M 2 🗓 F 08/08/1922 Country) Director 219-41-8776 88 UKRAINE Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 🗆 Yes 🛪 No MD BALTIMORE OWINGS MILLS ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 11100 HIDDEN TRAIL DRIVE 21117 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items unty or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner muy or other traumatic event, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify WHITE 1 16a. Decedent's Usual Occupation rGive kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LEIBA TS IMERMAN SARA **ESTERMAN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELENA KUPERMAN/GRANDDAUGHTER 11100 HIDDEN TRAIL DRIVE, OWINGS MILLS, MD 21117 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CONGR. 03/09/2011 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ EPSI disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DISEASE Yes 2 4 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific. 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 2 ER/Outpatient 3 DOA hours after death. uneral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier сопріете (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tipe of certifier 19502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORIANDO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ March $\mathbf{I}^{ay}, 201^{Yaar}$ 10:37AM Marie Ann Russo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2710 Taylor Avenue Baltimore Parkville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours Jan 19 1941 Maryland 218-36-9602 70 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 6128 Marglenn Avenue U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes X☐ No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Leo Matassa Ann Carnaggio 19a. Informant's Name/Relationship (Type, Print)
Anna Oleszczuk/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6128Marglenn Avenue, Baltimore, Maryland21206 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

MorelandMemorialPark3-7-11 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P. muhael 6009Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 419 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Wo
9 Unknown 4 Pregnant Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Daughter's Other: 4 Nursing Home STAREsidence 6 T Other (Special မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 12 person who completed cause of death (Item 23a) (Type, Print) TIMONIUM 2300 DuckNey 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) ROGERS **Physician** ARSARGI Marc 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Catonsville Commons Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Aug. 7, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Min Maryland 1 □ M 2 K F 84 214-24-1542 Aug. 1926 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐XNo MD Catonsville Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 United States 303 Maiden Choice Lane, Apt. 321 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Yacht Club Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Estelle Norwood Vernon Porter Zang ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 324 Stafford Drive, Catonsville, MD 21228 Patrice Dietz - Daughter 20c. Location - City or Town, State Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3-10-2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service License 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tath. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final ev hysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executer burial-trai Division of Vital Records, P.O. Box 68760,>Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknowr ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Onknown icate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed certificate 2 🗆 No 1 ☐ Yes 2-INO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

TURAKHIA

31. Date filed (Month, Day,

32. Registrar's Signature

rederige

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 500 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician kan maan no deed 2011 larch /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner NA The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 212-60-0487 61 06-06-49 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County tX Xyes 2 □ No Director or other traumatic event, the Medical Examiner must be notified MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1720 N. Milton Avenue 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: American \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) 2yrs. Barber Touch of Class 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Hayward Trice, Sr. Vara Mitchener ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai 876 Lowe Road Middle River, Maryland Akil Trice-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Xurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. 03-08-11 Randallstown, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical HUROXIC respiratory disease or condition resulting in death) Examiner respirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Embolization 2 No 3 Probably 4 Unknown Pulmonary 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? congestive iteart 24a. Was an Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred I Director: After the din by the funeral 5 Pending investigation Injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 🗌 Yes 2 No 2 Accident 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) RES-000 March 5, 2011

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rebecca Dezube MD Johns Hopkins Hosp.

32. Registrar's Signature